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Official Report of Debates (Hansard)

Thursday 10 September 2009

Select Committee on Mental Health and Addictions

Mental Health
and Addictions Strategy

Chair: Kevin Daniel Flynn
Clerk: Susan Sourial

Assemblée législative de l'Ontario

Première session, 39^e législature

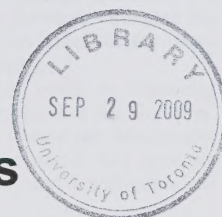
Journal des débats (Hansard)

Jeudi 10 septembre 2009

Comité spécial de la santé mentale et des dépendances

Stratégie sur la santé mentale et
les dépendances

Président : Kevin Daniel Flynn
Greffière : Susan Sourial



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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

SELECT COMMITTEE ON
MENTAL HEALTH AND ADDICTIONSCOMITÉ SPÉCIAL DE LA SANTÉ
MENTALE ET DES DÉPENDANCES

Thursday 10 September 2009

Jeudi 10 septembre 2009

The committee met at 0901 in the Howard Johnson Plaza Hotel, Sudbury.

MENTAL HEALTH
AND ADDICTIONS STRATEGY
COMMUNITY COUNSELLING
CENTRE OF NIPISSING

The Chair (Mr. Kevin Daniel Flynn): Can you hear us, Elaine?

Ms. Elaine Cousineau: Faintly, yes.

The Chair (Mr. Kevin Daniel Flynn): Good. We're all sitting here. You're our first call of the day. All the members are present right now. There are some people in the audience here in Sudbury. Everybody on this leg of the tour is being given 20 minutes to make a presentation.

Ms. Elaine Cousineau: Yes, I understand.

The Chair (Mr. Kevin Daniel Flynn): So if you would use that any way you see fit, and then at the end of the presentation, if there's any time that's left over for some questions or discussions, we'll see if we can't share that amongst the members who are here.

Ms. Elaine Cousineau: Okay.

The Chair (Mr. Kevin Daniel Flynn): Everyone can hear you at the level that you're talking at now, so just make yourself comfortable.

Ms. Elaine Cousineau: Okay. Thank you.

The Chair (Mr. Kevin Daniel Flynn): And it's all yours.

Ms. Elaine Cousineau: Thanks very much. Good morning to the Chairperson and members of the select committee. My name is Elaine Cousineau. I'm presently the fetal alcohol spectrum disorders education coordinator at the Community Counselling Centre in North Bay. Thank you for this opportunity to express my concerns to you.

In the 1980s, over 24 years ago, I was a member of the Focus community, one of nine anti-drug coalitions across Ontario. The members of this grassroots group in North Bay felt it was important that I be a voice for many families coping with youth caught up in the drug scene and that I should accept the invitation to make a presentation to that task force travelling across northern Ontario to address alcohol and drug issues.

I shared with this task force the grief my family was experiencing with our beautiful young daughter, who was, at the time, making suicide attempts, getting into

trouble with the law, running away from home, cutting herself, drinking and doing drugs, skipping school and suffering mentally, physically and emotionally. We had sought help from 27 different professionals—counsellors, doctors, psychiatrists, psychologists and agencies—all to no avail.

At the end of my presentation to that group of politicians, one of the members, Mr. George Mammoliti, a young MPP from Toronto, came forward, extended his hand and said, "Mrs. Cousineau, on behalf of the province of Ontario, we owe you an apology."

My daughter, like many other youth in Nipissing district, had fallen through the cracks. For the first time during our nightmare I felt heard. I knew Mr. Mammoliti understood, and I sensed that he cared. His apology meant so much to me at that time, and I was confident that there would be help soon.

Before very long, I accidentally learned through poring over the Internet that there was a disorder which presented with the following behaviours: running away from home, not understanding consequences, truancy from school, promiscuity, trouble with the law, drug and alcohol use, and depression and suicide attempts, and there had been a label for this disorder for over 10 years. The term "fetal alcohol syndrome" was coined in 1973 in Seattle, Washington. My daughter, whom we adopted as an infant, had been exposed to alcohol in the womb, so immediately I sought help, but I could not find a soul in North Bay who knew what FASD was.

Today, after many years of learning about FASD, I'm told by front-line workers that families today would not have experiences similar to mine and that there is help for families coping with FASD in our district.

Well, I'm here to tell you today that youth in North Bay are continuing to fall through the cracks because no group, no ministry, no organization is accepting responsibility for helping these individuals whose lives have been ruined by being exposed to alcohol while in the womb.

I'm assuming that most of you know what FASD is. It is not a developmental delay. It is permanent, irreversible brain damage caused by alcohol use while pregnant. It is the leading, number one cause of birth defects in North America and it's 100% preventable. If the fetus is not exposed to alcohol while in the womb, it cannot have fetal alcohol spectrum disorders.

For several years now, I have advocated mostly voluntarily for youth in trouble with the law, in trouble in

school and at home. I've visited these kids in jail where we're told it is the last place they should be because they're so vulnerable and easily led. I answer frantic phone calls from parents, grandparents and foster parents desperately seeking help. I've accompanied parents to North Bay police station at midnight because their child has been arrested and does not even have a clue why he's being arrested, even though he tells the policeman he understands the charges.

I'm presenting to you today to impress upon you the need for someone to address fetal alcohol spectrum disorders. We're told that 1% of all babies born are affected, yet we're also told at conferences in British Columbia that we don't have accurate stats and that when we do, the numbers will be alarming. Yet, we still have doctors telling young women that a few drinks won't hurt and we have school boards refusing to provide the one-on-one assistance that is needed for students with FASD because they don't have psychological evaluations on record with the school. The parents I know are struggling to keep food on the table and pay the rent so they won't be evicted. They do not have the money for a \$2,500 psych assessment from a psychologist.

We have lawyers representing youth in court who have no idea how the client has been affected by alcohol before birth. They interpret the client's inattention as disrespect for the crown. Little do they know that the client is so easily distracted, he can't even focus on what the lawyer or the judge is saying.

There are some support and services for many of the aboriginal groups, but non-aboriginals have been left to fend for themselves.

At one of the many conferences I have attended in BC—incidentally, at my own expense—a doctor specializing in FASD said in front of the audience of 700 people, "If you're a native, you will get a diagnosis of FASD. If you are white, you'll get a diagnosis of attention deficit disorder because it's more socially acceptable."

The Trillium Foundation of Ontario has just recently provided funds for providing FASD education throughout Nipissing district. We have received \$120,000 for a two-year contract and we are truly grateful for the generous gift. However, it was shame and embarrassment that I met in a family support group because the media had misrepresented the facts, stating that families were now going to get some support. The families have got nothing.

0910

Do you know what families need? They need respite workers so they can get a break from their child, who seems to be in trouble continuously. They need someone to supervise their children 24 hours around the clock so they can sleep without having to worry if their son or daughter has sneaked out of the house once again and is getting into trouble with the law.

They need legal representation because these children are targets for other youth and often end up, sometimes even willingly, taking the rap for a crime they did not

commit. Not long ago, a boy was invited by friends to break into a liquor store. When the police arrived there was no booze, there were no friends, but guess who was arrested for stealing the liquor? Last week, a 30-year-old woman came to me to learn about FASD because she just can't figure out why she may be going to jail. She's attractive and had a career, but she met a young man who saw an opportunity to use her, and today her \$12,000 savings are gone, her career is gone and she too has charges that she does not understand. In fact, she has six of them.

I sat at meetings to assist a family where we were surrounded by numerous agencies that were involved because the child was misbehaving in school or skipping school or failing to succeed in school because he was simply overwhelmed and unable to carry out the tasks given. Every single representative from every single agency around that table simply replied, "That's not my mandate," until finally the father, who was at the end of his rope, threw himself forward on the table and sobbed, "I just want help for my son." Eventually that father left a message on my answering machine, threatening suicide. These parents are absolutely devastated and can no longer cope.

Often, mums who have FASD themselves are trying to raise children with FASD. They struggle with their own addictions, and they're totally unable to help their children with their addictions. Did you know that individuals with FASD are prone to addictions?

Last week a partnering agency brought a 14-year-old young man to me, hoping I could explain to him what FASD was and how it was affecting his life. This boy is abusing both drugs and alcohol. I learned that his father, from whom he had just ran away, is a drug addict and an alcoholic. His mum, who suspects that she herself has FASD, is struggling with her own addictions. She has a new partner and they're both on the methadone treatment program. Grandma, too, is an alcoholic. When do we stop this flow of alcohol and drugs to our youth?

Who should be responsible for giving these children what they need to survive? We know what they need. They need, number one, an exterior brain. FASD guru Dr. Sterling Clarren from BC says they will need someone else to think for them for the rest of their lives. They need structure and guidelines. They can't make choices that are safe. They need quiet homes with no conflict. They need education with the proper one-on-one supervision, if necessary. They need legal representation. They need counselling for addictions, not by ordinary addiction counsellors but by counsellors who understand FASD. They need careers where they can become contributing members of society. They need respect from the community. They need assistance with handling money and life skills. They need a chance to cultivate their own interests. They need people who will help them reach their potential.

According to the Public Health Agency of Canada, there are 300,000 people living in Canada with FASD, and estimated costs range from \$2 million to \$5 million to raise each child affected by alcohol.

When these youth reach adulthood, if they can be kept alive and out of jail, they frequently are able to have a job, but they may need extra training by employers who are educated about FASD.

Children who have FASD are delightful people. They're eager to please, so much so that they frequently admit to police officers doing things they didn't do, just because they want to please them. They're conscientious when given appropriate supervision and instructions. They have a sense of humour. They love animals. They want to be independent, contributing members of society, and they can, if provisions are made.

A few years ago, the crime prevention centre provided funds to have a needs assessment done in the district of Nipissing. The gaps in services were significant: lack of adequate respite for parents, and lack of education about FASD for doctors, lawyers, police, front-line workers. Few of those gaps have been filled for the mainstream community.

In the 1980s, MPP George Mammoliti's apology was sufficient. To the Select Committee on Mental Health and Addictions on September 10, 2009, I'm saying that no apology will suffice today. Only steps toward addressing FASD problems are acceptable.

I'd like to close by reading a letter by one of the parents. I hope it will move you as it has moved many others. Others have been sympathetic, but they have no resources. You, the Select Committee on Mental Health and Addictions, are in a position to bring about the change which is so badly needed. Here are excerpts from the letter, which I have permission to read. I choose to omit the father's surname.

"My name is John, and I live in North Bay, Ontario.

"I'm a single father, struggling to raise two children. My daughter is 16, and my son, who's 14, has fetal alcohol spectrum disorder. I would like to see community agencies more aware and more involved with families like mine.

"For example, when my son was arrested, the police did not know about FASD and did not appear to care. I believe they need to know much more before these kids end up in jail.

"They have permanent brain damage and there is no cure, but with help from services in the community, my son, and others like him, could receive proper help if we had funding. In our district, we have to have our own diagnostic clinic instead of having to drive to Toronto.

"My son and I were both mistreated by the school and by the police because of their lack of education of FASD. Our frustration over agencies' apparent lack of knowledge has caused constant anguish and frustration. I've been called a bad parent because of my son's actions when, in fact, had they been knowledgeable about FASD, they would have understood the reason for his behaviours.

"There is help for drug addicts and there is help for alcoholics who choose to drink and do drugs, but there is no help for our children who did not ask for this disease.

"Sincerely,

"John."

I'm open to questions.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Elaine. Thanks for your presentation. You will be the third person that has spoken to us on FASD. Each time somebody else talks to the committee, we get a little bit more information.

You've left a good amount of time for questions. We're going to start with either Christine or Sylvia.

Mrs. Christine Elliott: My name is Christine Elliott. I'm one of the members of the committee. I thank you very much for your presentation today. It was quite helpful and illuminating.

One of the things that we're struggling with is—I agree with you; there is a need to educate physicians a little bit more on the effects and the presentation of FASD, as well as police, teachers and so on. But on the other hand, you have this sort of apparent contradiction that once there's a label that can be applied to it, people are reluctant to accept the label because of the stigma that seems to be attached to that.

What would your thoughts be on how to deal with that?

Ms. Elaine Cousineau: The parents that I see—their children are already labelled "stupid," "retarded," all kinds of things. They are very relieved to find a label that is meaningful. We're trying to bring it out of the closet. I try to assure these people that there is no shame. No mother ever, ever intentionally hurts their child. The circumstances: I guess she used alcohol for the pain or didn't know.

I did an FASD day yesterday in the mall, and I am shocked at the number of young girls—out of grade 12, going to university, she did not know alcohol could cause damage in pregnancy, and she has already had a baby.

I don't mind the label. The people I work with don't mind the label. I think it's how it's handled.

You did mention something about doctors needing more training. I understand they get hardly any. In fact, somebody showed me a textbook; I think there probably were 20 lines about FASD.

Mrs. Christine Elliott: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you. France?

M^{me} France Gélinas: Hello, Madame Cousineau. I would be interested in finding out, and if you could explain to the committee briefly, the steps you had to go through to get a diagnostic service for your son.

I'm from northern Ontario. A lot of people that I've talked to have to go through a lot of, let's just say, pain and heartache to get a diagnostic clinic mainly because we cannot get one in northern Ontario. I would like you to share your experience with the committee.

0920

Ms. Elaine Cousineau: I can share what I'm doing with many of families that come to us. I'll give you the example of a young mom who, herself, in her own words said, "I know I have FASD. My mom drank." She saw the characteristics in herself. She has three children that

she drank with, so we sent her down to Toronto, to St. Mike's hospital, to Dr. Brenda Stade's clinic, to get those children diagnosed. Can you imagine travelling four and a half hours in a car with three children with FASD and staying overnight? It's horrific. And she was a lucky one because we were able to get some financial support for her, but other families who don't have that support don't get it.

We also have tried a telediagnostic clinic. It worked well, but St. Mike's hospital paid for our five kids to be diagnosed that day. We should be paying for our own kids to be diagnosed. I tried to get a diagnostic clinic going here, even though a Sick Kids hospital representative once said to me, "Elaine, you'll never get a diagnostic clinic in North Bay." Well, I have five pediatricians interested. I've got a speech therapist. I think I've got seven people altogether.

When we met, the psychologist's first words to me were, "Who's going to pay us?" And I said, "Do you think I should have had the finances in place before I called the people together?" He said, "Yes," and I said to him, "How will I ever get financing and funding if I can't prove I've got people interested?" So he seemed to agree with me. But if we need the diagnosis now, we have to send them down to Toronto.

M^{me} France G  linas: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Are there any questions from this side?

Thank you for joining us today, Elaine. It was really informative.

Ms. Elaine Cousineau: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you for taking the time out of your day. As I said, you're the third person who has approached us. We heard from people in Toronto and we heard from people from fetal alcohol syndrome organizations in Ottawa yesterday as well.

Ms. Elaine Cousineau: Wonderful.

The Chair (Mr. Kevin Daniel Flynn): So you're starting to get your message across, if you think you're not.

Ms. Elaine Cousineau: That's a relief. Thanks very much.

The Chair (Mr. Kevin Daniel Flynn): Thanks for joining us.

Ms. Elaine Cousineau: Bye.

The Chair (Mr. Kevin Daniel Flynn): Bye. Thanks to the audience for listening in.

SUDBURY ACTION CENTRE FOR YOUTH

The Chair (Mr. Kevin Daniel Flynn): It's 9:20, and our next delegation is from the Sudbury Action Centre for Youth; Mardi Taylor. Make yourself comfortable. Everybody is getting 20 minutes in this round. There are some clean glasses and some water if you need some. Use the time as you see fit, and then, if there's any time at the end, we'll split it amongst the members who are

here today. The mikes seem to work best when you're about a foot away from them.

Ms. Mardi Taylor: Okay. I'd also like to introduce Ken Wallenius. He is the youth program coordinator at the Sudbury Action Centre for Youth.

The Chair (Mr. Kevin Daniel Flynn): Welcome, Ken.

Ms. Mardi Taylor: Good morning. My name is Mardi Taylor. I'm the executive director of the Sudbury Action Centre for Youth, and I appreciate the opportunity to address the committee today.

I'd like to tell you a little bit about our agency. We were established in 1986, and we exist to serve the most vulnerable members of the Sudbury community. We offer programs through three main program areas: our casual labour employment centre; our harm reduction area, including IDU/HIV outreach and a fixed-point needle exchange program; and our youth program and drop-in.

Our casual labour employment centre is actually the original program of the agency. As you can see on your handout, it's there to offer an honest day's pay for an honest day's work. For the latest fiscal year ending March 31, 2009, we placed 304 clients—50% of them had no income; 33% of them are homeless—in a total of 3,888 short-term and casual labour jobs. We also assisted 600 employers. Who makes up the main percentage of our employers? Over 80% of them are seniors owning residences in Sudbury. So this program also provides a valuable social service in assisting people to stay in their own homes. We also offer clients assistance preparing cover letters and res  m  s and with their job search.

In our harm reduction area, we offer an injection drug users/HIV outreach program five nights a week. We distribute harm reduction supplies to clients, and we go to where they are located. We offer education, information and support.

With the Point needle exchange, we distribute, on average, 21,000 clean needles per month and take in almost an equal number of used needles through our needle exchange program. The needle exchange, the Point, has been awarded a national award through the Donner award foundation, and is, again, a finalist this year of over 550 agencies from across the country. We feel that we have a pretty good track record, and we feel that we know what we're doing in the area of addictions, specifically.

But I'm not here to talk to you about that today. Today I'm here to talk to you about our youth and the struggles that they face, and I'd like to tell you a little bit about our youth drop-in. Our youth drop-in is a safe, non-judgmental place, where at-risk and high-risk youth can go in the Sudbury community. We're open Mondays and Tuesdays from 8 a.m. to 8 p.m.; Wednesdays to Fridays, 8 a.m. to 10 p.m.; and Saturdays from 2 p.m. to 10 p.m. Through the youth drop-in centre, there's always a trained youth worker on duty. We offer recreational activities for the youth to engage in, all at no cost. We serve hot meals every day that the drop-in is open. We

also offer a full-time housing support worker, because approximately half the youth who access our centre are homeless. We have a new partnership that we're beginning with one of the local school boards, where we have a teacher in the drop-in daily to help the youth improve their education and to assign high school credits. And through the drop-in, we also offer a variety of programs and services.

That's why I'm here to talk to you today. I want to talk to you about the mental health and addictions awareness group that we offer through our program. Right now, it's funded through a three-year Trillium grant. We offer a weekly workshop where youth discuss mental health and addiction issues. Keeping in our philosophy to truly engage our youth, we encourage youth to set the agenda and determine the content. For example, topics from this month include pregnancy and mental health; epilepsy; positive thinking; and your body, your rights, your responsibilities.

Some current numbers for you for this past year ending August 2009: 62 registered clients, all of whom are youth between the ages of 16 and 24 years of age, accessed the program; 25 of these clients were or are actively struggling with addiction issues; 29 of these clients are struggling with severe mental health issues; and 15 of these clients are dealing with both. These 62 clients accessed the program over 230 times, but unfortunately, our funding, our Trillium grant, ends next month; it ends at the end of October 2009. Now, that Trillium grant was for a total of \$75,000 over three years, so I think that was pretty good value that was offered for the funding.

The issue in my mind is the lack of core funding to support groups such as this. The lack of core funding results in a lack of continuity in programming and services offered; also, a lack of continuity in stability in staff. For example, for this three-year project we had a total of three staff, because the problem is, it's a contract position, and as soon as they get a more stable job, off they go. I don't blame them, but it makes it very, very difficult to keep the continuity. We continued to offer excellence in service, but the problem is that when the project grant ends, the program ends.

0930

What needs to change? Well, I think we need to support community-based programs such as the mental health and addiction awareness group through core funding, because this kind of program provides immediate support. There are no wait lists, there's immediate crisis support and we're able to offer our clients referral to programs which can help them. In the meantime, we can keep them safe while they're waiting. The awareness group educates the clients about the system and how to access services and the youth also receive support through the drop-in and their relationship with our youth staff. They're here in the program and the drop-in anyway and they feel safe. It's a safe place for them.

Our staff is also well qualified to provide this service. All of our staff have a minimum of post-secondary

education in counselling or some sort of social service program. The majority of our youth staff are graduates of the child and youth worker program at community college. But we also have a registered social worker on staff, and we also have another staff with a university degree. One of our staff is even a former client of our program whom we assisted. She went on and got her social service worker's diploma, and now she serves as a wonderful example and role model for youth—that they can make it, so to speak. Our needle exchange manager has a master's degree. So all of our staff are very well qualified. Yes, we're front-line, but we do that because we choose to do that.

We offer wonderful, immediate support when the client can't access the services and programs, or inpatient or more therapeutic programs right away.

We need core funding because this kind of group needs to continue. We see it all of the time. We see our youth come in every day. It needs to continue, but it won't.

I want to talk to you a little bit about one of our clients. We're going to call her Sarah. Sarah is actually a composite of several youth who have gone through this awareness program. She's female and is aged 21. She's struggling with depression and has been addicted to opiates and alcohol for the past eight years. When she was younger, she was molested by an older man and this man had hepatitis C and was HIV-positive. When she reported the abuse and the man was sentenced to jail, he threatened to kill her when he got out. Others in Sarah's environment also threatened her and spread rumours that she was also infected. Sarah experienced several depressive episodes and attempted suicide by jumping off a building. With the help and support of the awareness group and the group facilitators, Sarah is attempting to enter rehab and get her life back on track. The group continues to support her while she waits to enter the rehab.

What's going to happen to Sarah? Our final awareness group is Wednesday, October 28, 2009. That's about six weeks away. Although we've applied for private foundations and other proposals, they've been turned down. We no longer have funding to continue this program. The awareness staff facilitator who is our registered social worker will be out of a job, and that's a loss not just for the program but for us as an agency and especially for the youth at our centre, because it takes a long time to build up that trust and build up that relationship. But most importantly, what will happen to Sarah and the other 61 youth who've been through the program this past year?

Unfortunately, this isn't an isolated problem, because most of our agency's programs on the youth side—what we do—are all funded through project-based funding. So when the project ends, the program ends. Staff turn over more frequently because they don't have job security or stability.

We're not the only agency facing this. It's difficult for all local agencies to offer consistency and programs and staff for clients who need it the most.

I'm asking you here today to consider and take the message back for the government to invest in core fund-

ing of these types of programs because it allows the community partnerships to work; for example, our partnerships with the school board and with the Greater Sudbury police. Our agency is very unique. We do what nobody else in Sudbury does. We're also very good at working with our community partners, such as the school board, such as the Greater Sudbury Police Service. Lots of times we have the police drop the youth off at our centre because they'd rather have them come to our centre than take them to jail.

We're more than happy to explore working with the medical and clinical and therapeutic system. We can offer the immediate support that our clients need. I'm sure your committee has heard clients and consumers tell you over and over again that they cannot wait, that when they are ready to go, they want to go now; they need the help now. I'm asking you to let us help. That's what we do, and we think we do it really well. Core funding will allow us to keep doing what we do best: provide immediate, front-line support for Sarah and all the others.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Just for the benefit of the committee, just to aid in everyone's evaluation, on slide number 7—it's a kind of process-oriented slide; it's not very outcome-oriented—you've got 62 clients who were registered between August 2008 and August 2009. How many of those were you able to move into active treatment, into rehab or into treatment programs?

Ms. Mardi Taylor: I don't have that information with me. I can find out.

The Chair (Mr. Kevin Daniel Flynn): Could we get it?

Ms. Mardi Taylor: Yes.

The Chair (Mr. Kevin Daniel Flynn): Good. Thank you, France?

M^{me} France Gélinas: Good morning. It's nice to see you. Maybe I'll take you back to his question, but frame it a little bit differently. Can you talk to us about the waiting lists for services or the lack of services available to your clients? Your clients go to you, there's no waiting list, they're in that really privileged situation where they want change in their lives, either to get into Iris recovery or to get into some kind of other programs—but either those programs are not available in Sudbury or the waiting lists are very long. Sarah could have gone to Iris Addiction Recovery for Women, but how long is the waiting list to go there, or for any other services—because I know you have a long list of partnerships.

Ms. Mardi Taylor: I know that the staff over in the harm reduction area talk about their clients having to wait three to six months, depending. There is also an in-treatment program in North Bay that they sometimes go to, and there's usually quite a long wait for that as well. There's not a lot even available for them to go to, but the hospital programs—we were meeting with them last week, and usually it's at least weeks for them to get in through something at the hospital. I'm not up on everything that's available because it's more the front-line staff who know that kind of thing, but it's certainly

not immediate. So we're talking anywhere from six weeks to a matter of months, if it's more of a residential kind of treatment.

M^{me} France Gélinas: Some of your clients are very young, so if you want to talk about the issue of income support—they don't qualify for OW—and all the problems that this brings, as well as housing them.

Ms. Mardi Taylor: The 16- and 17-year-olds, specifically, have no income because a lot of them don't have adults in their lives who can act as the guarantors. So when they come to us, they have no income, no support. They're homeless.

0940

Our housing worker spends a lot of time, but there's really not a lot that they can do. So in the summer, we've got tent cities all over the city. Many of her clients are in tent cities. During the winter, of course, there's not a lot of shelters. There are two youth shelters in Sudbury—one for females, one for males—up until the age of 18, but they're very, very restricted in terms of abstinence, that kind of thing. A lot of our youth just can't follow those rules and so they basically are kicked out of the shelter and then they have no place to go. So our housing worker is doing revolving-door work.

When you combine all of these issues with issues like mental health and addictions, it creates a real problem, which is why we have our drop-in. I've given you the hours, but we need to be open more.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Mardi. We're going to move on. Maria, and then Jeff, if there's time.

Mrs. Maria Van Bommel: Thank you very much. You're the Sudbury Action Centre. Do you serve just the greater Sudbury area or do you serve a greater area than that?

Ms. Mardi Taylor: People come in from outlying areas, but we're located right downtown, where most of our clients are.

Mrs. Maria Van Bommel: You talked about the Point needle exchange, the numbers. I did quick math and it works out to over 600 a day that you're distributing. That's quite a lot. Is that number trending up or trending down, and can you explain what might be happening out there?

Ms. Mardi Taylor: It's trending up. Actually, our high point was May of this year, when we distributed 33,000 clean needles. We're second in the province to the Toronto needle exchange, but obviously our population is much less. The reason our needle exchange is so successful, if you will, is because the health unit contracts us to run the needle exchange and we're located right downtown where the majority of the clients are. We're easy, we're accessible, we're anonymous and we're now getting the word out.

There is core funding for that program, and our two needle exchange staff have been there for 15 years. So as you can imagine, the relationships have been built up and the numbers bear that out.

Mrs. Maria Van Bommel: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Jeff?

Mr. Jeff Leal: Thank you very much for your compelling presentation. What's your relationship with the local LHIN that covers Sudbury—the local health integration network—in terms of their planning and work in a variety of health-related areas?

Ms. Mardi Taylor: We receive no LHIN funding. I don't have a relationship with them.

Mr. Jeff Leal: My second question: Are you also seeing—many police forces across Ontario are seeing a dramatic increase of youth using OxyContin and Percocet. Is that a trend here in Sudbury too?

Ms. Mardi Taylor: Yes.

Mr. Jeff Leal: My last question is: Our previous presenter talked about fetal alcohol spectrum disorder and talked about having 15 agencies together at a table and none of them able to help someone's son. Do you see that as a bit of a barrier, that we have multi agencies that are not getting to the core of the problem?

Ms. Mardi Taylor: I would say that many of our clients have fetal alcohol syndrome, and our workers are very aware of the problems there.

I think, in Sudbury, we do a good job of sharing resources and not duplicating services, but I think it's certainly something—it's always good when the agencies get to the table and agree to provide services in a coordinated manner.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Mardi. We're going to have to move on. We're actually out of time. Sylvia's got a very brief question and hopefully a very brief answer.

Ms. Sylvia Jones: You mentioned that you had tried to access some private foundation money, knowing that the Trillium grant was coming to an end. Have you approached children and youth services with that problem?

Ms. Mardi Taylor: I wrote children and youth services and I have written them again, but—

Ms. Sylvia Jones: No response?

Ms. Mardi Taylor: Well, I got a response last fall saying that there was no funding available for us. We're not funded—any of our programs—through them.

Ms. Sylvia Jones: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Jeff, did you have a brief question that needed a brief answer? If we can do it—

Mr. Jeff Leal: No, I'm okay.

The Chair (Mr. Kevin Daniel Flynn): You're okay? Good. Okay. I want to keep us moving along. I don't want to cut off the debate.

Thank you very much for your presentation. Thanks for what you do on the streets as well.

Ms. Mardi Taylor: Thank you for your time.

CANADIAN MENTAL HEALTH ASSOCIATION,
SUDBURY-MANITOULIN BRANCH

The Chair (Mr. Kevin Daniel Flynn): We've got the Canadian Mental Health Association, Sudbury-

Manitoulin branch; Marion Quigley and Michael Clark. Make yourselves comfortable. There's some water and clean glasses there if you need it. Everybody's getting 20 minutes, as you've seen. You can use that time as you see fit, and at the end, hopefully there will be a bit of time for some questions. The mikes seem to be working well this morning. Hopefully I haven't jinxed them now by saying that. They weren't working well in Ottawa yesterday. It's all yours.

Ms. Marion Quigley: Good morning. My name is Marion Quigley. I'm the chief executive officer of the Canadian Mental Health Association, Sudbury-Manitoulin. I'm joined here today by Michael Clark, who is a "warm line" coordinator at our office.

The Canadian Mental Health Association was established in 1984 and is a not-for-profit organization with a volunteer board of directors, and is mandated to provide services to adults 16 and older with a diagnosis of a serious and persistent mental illness within the Sudbury-Manitoulin district.

CMHA is an agency that is primarily funded by LHIN 13 and the Ministry of Health and Long-Term Care, and also receives funds from the Ministry of Children and Youth Services, United Way, the city of Greater Sudbury, the Ministry of the Attorney General and the Ontario Trillium Foundation.

CMHA provides services through a recovery and rehabilitation approach by assessing and developing readiness for change and helping people regain a meaningful role in their community. This approach runs throughout our organization and includes how things are done, how we communicate, how decisions are made and how we live our values. It is about how we respect and value individuals and how we create a healthy environment for our clients.

Today, we're here to talk frankly about our clients' needs. First, I want to give you a few statistics: 10.4% of Canadians are living with mental illness; roughly two thirds of those who experience mental illness do not receive treatment; 86% of homeless people show symptoms of either mental illness or substance abuse.

In 2008, in the city of Greater Sudbury, there were over 1,300 people at imminent risk of homelessness and over 600 people living on the street.

It has been known for a long time that people who have lived through mental health issues have a better chance at recovery if they have a home, a job and a friend. People know this intuitively; many government officials do, too, but the complex nature of our province's bureaucracy makes it difficult to address the holistic issues of persons with lived experience, and makes it confusing and somewhat inaccessible for those persons, which can lead to homelessness, poverty and joblessness, along with attendant emotions of alienation and isolation.

Recovery is the foundation on which all CMHA mental health services are provided. Recovery is a journey of healing and transformation that helps a person with a mental health problem live a meaningful life while striving to achieve their full potential.

Psychiatric rehabilitation is the process CMHA in Sudbury utilizes to provide services to assist clients in receiving the skills and supports they need in order to be both successful and satisfied in the living, learning, working and social environment of their choice. We believe in the potential that individuals can move beyond remaining a mental health patient to attain a meaningful role in society when skills and supports are provided.

I'm happy to tell you that there has been considerable progress in the acceptance of mental health issues in our communities over the past five years due to public awareness programs. This has been proven to us through an increase in referrals to our organization. We are continually working with our northern partners to look for opportunities to inform our communities on good mental health practices.

Further, we recognize that a key priority of the select committee is to improve health system access and navigation. We'd like to identify some initiatives that are under way in our community that would demonstrate this.

The Ontario Common Assessment of Need, OCAN, project is being piloted in LHIN 13 to enhance the sector's capacity to streamline and standardize the assessment process. This common assessment tool will ensure that every consumer is assessed using a standardized decision-making tool that allows key information to be electronically gathered in a quick and secure manner. It offers consumers an effective way to voice their needs and preferences for care and is consistent with a recovery approach.

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CMHA has had an information referral program for several years to assist people in navigating the mental health and addiction system. Through ministry funding in 2003 CMHA expanded this program to the community mental health programs at the hospital. So we now have one of our staff working at their site. In our community we want people to find services they need at whatever door they enter.

We're currently working to enhance our central intake program on Manitoulin Island with our partners there.

We also want to stress the importance of case management as it improves access and coordination of services for persons who are marginalized and at risk of falling through the cracks. We have found that case management has been shown to significantly improve housing stability and community functioning, and to reduce visits both to the emergency department and hospital admissions among people with serious mental illness. As an example, this is seen through our release-from-custody program.

But in the context of our recovery-oriented practice, we see a variety of gaps in our mental health system, including in social service and health system navigation, housing, employment, social supports, and the justice and court systems. I'll address each of these in turn.

System navigation: First and foremost, as a province and as stakeholders in the mental health system here in

Ontario, we need to do a better job of coordinating policies and programs between various ministries and organizations at the interface of need, diagnosis, rehabilitation and recovery of individuals, so that they experience smoother transitions and better outcomes for themselves and society as a whole.

Primary health care: People with mental illness in Ontario often have difficulty getting primary care, such as seeing a family doctor. At the same time, family doctors are often the first point of contact with the health care system for people with mental illness, and many of these family doctors need support in pursuing treatment for their patient's recovery.

We need to ensure that all individuals have access to primary health care. Overcrowded emergency care, the lack of family physicians, few trained psychologists and psychiatrists, particularly in the north, where there is an increased need for psychiatric and psychological post-traumatic stress counselling for survivors and descendants of residential school survivors—the list goes on.

Committee members, as you can imagine, it's hard to navigate a system that has pieces missing. Just imagine that you have few coping and interpersonal skills—it's a very dark image to conjure in the 21st century.

Housing: From my experience, the most important issue facing our clients today is housing in our community. Everyone needs to live somewhere in order to be able to work or play. According to the Housing Network of Ontario, creating and maintaining stable, available, accessible and adequate affordable housing is good social policy. People in stable housing are more healthy, more productive, do better in school and become more engaged in their neighbourhoods.

Right now, CMHA provides 24 units of apartment living with minimal support; an eight-bed shared-living home with medium support; housing outreach; property services and rent supplement.

Our housing services are provided in the context of our recovery-oriented philosophy. We have an integrated approach to addressing both mental health and addiction issues to help ensure that clients receive both support and skills necessary to be successful. Our property services administer the rent supplement program, which provides some financial assistance to approved agency applicants with their rent to reduce the risk of homelessness and obtain affordable housing.

In our community, we have been in the business of supportive housing for a very long time. There's been an increased demand for housing for individuals requiring rent support. Market rent has increased dramatically, and the 0.3% vacancy rate in the Sudbury district makes it difficult for individuals to find and afford decent housing. Unfortunately, we don't have enough housing to fill the need. People who come to us are waiting for two years or more to be accepted into our housing program.

However, we also know that many, many people with mental illness, some of whom are at serious risk and who may not know of or use our services, live in substandard housing in our community that is physically inadequate,

crowded, noisy and located in undesirable neighbourhoods.

Maintaining and improving the housing of individuals with serious mental illness can contribute to a reduction in psychiatric symptoms and decrease the need for emergency and treatment services.

Supportive housing is economical. It costs far less to provide supportive housing than to provide a shelter bed to a homeless person or care in a psychiatric facility. According to the Mental Health Commission of Canada, as quoted in the *Toronto Star* this past year, it costs \$34,000 a year to support someone living with a serious mental illness in the community compared to \$170,000 to keep them in a hospital-type setting.

Housing is essential for recovery, and there is a shortage of affordable housing as well as supportive and supported housing in our area—the definitions are in your handouts today.

People who can upgrade their living conditions often have increased opportunities to sustain employment, support a life of dignity and adequacy and attain essential social resources such as adult learning. Individuals living in poverty are more likely to develop a variety of illnesses and injuries, experience hospitalization, recidivism, mental health problems and difficulties in learning.

Finally, CMHA is in the process of securing funds to develop a housing implementation plan. Our community needs a road map that will allow us to identify and address a variety of gaps, such as the development of a 24/7 high-support home, a transitional home for up to three months' stay, accommodation for people leaving the jail system etc.

People with lived experience should not have to wait for two years, and they should have a choice of the type of home environment they require.

Employment, income and social supports: Research has shown that the recovery journey in the context of mental illness is complex and unique. Individuals have different understandings of recovery. One of the greatest needs in our community is more education about the recovery process and the values of the work experience to assist individuals to integrate, or reintegrate those in recovery back as a valued member of their community. Employers still seem misinformed about employment support services. We like the idea of more formal partnerships in this regard.

Strategies that promote social inclusion create environments that foster social connections, companionship and social support. Clients need access to affordable recreation and physical activity programs in our communities, opportunities for both youth and adults to participate in arts and cultural activities and increased structured opportunities for volunteerism and civic participation.

I just want to take a minute to talk about our clients and the justice system. Recently, Dr. Phil Klassen of the department of psychiatry at the University of Toronto stated the following to a group of crown attorneys:

"Most of the risk of committing criminal offences by mentally disordered people arises from factors other than

their mental illness, including factors like homelessness, isolation, poverty and age—which are better indicators of risk of criminal behaviour.

"Many people assume that people with schizophrenia always commit offences when they go off their meds and develop psychotic symptoms. However, 100% of people with schizophrenia go off their meds and develop psychotic symptoms at some point in their lives, yet only 20% to 25% of people with schizophrenia have criminal records. The clinical factors of people with the illness of schizophrenia are not a significant factor in assessing their risk of criminal behaviour."

There need to be better mental health supports in our jails. We need to work on those issues that put people in jail in the first place, such as the inability to cope, lack of skills, homelessness and poverty. Further, successful discharge of some of our clients from jail into the community requires enhancements of our community's supports to help those discharged to stay well. Our "warm line" and our release-from-custody program have evolved into such aids.

More housing options are needed to assist with individuals who are being released from custody and/or who are living in the community and part of our diversion program. This would address people who are involved with the justice program and have treatment needs. Some individuals are currently being sent to jail rather than receiving treatment. These individuals would benefit from a home that is staffed 24/7 and which would have a medical component, but would be less expensive and better suited to their needs than a jail or hospital bed—so a home, a job and a friend, housing, employment support, a helping hand when life is getting out of control.

I now want to let a person who has lived through these issues speak briefly about his experiences. Michael?

Mr. Michael Clark: Good morning. My name is Michael Clark. I'm a person with lived experience of mental health and addictions.

Fourteen years ago, I was an active IV drug user living on the streets of Vancouver. After coming back to Ontario, I found recovery and worked through a lot of childhood core issues. I was soon diagnosed with bipolar disorder and began a regimen of medication that lasted eight years.

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My first exposure working with mental health was in 2003. I was asked to work in a café in Kitchener whose main clientele was individuals with concurrent disorders. I got to know a lot of people on a personal basis, their struggles with their illnesses and addictions. Being in recovery for some time and then working with people with severe mental illnesses was like putting on the other shoe.

After coming back to Sudbury, one of my safe places was the Canadian Mental Health Association, and I soon learned of the various programs offered there. In 2008, I learned of the "warm line" program and filled out an application. I needed to complete some programs before

gaining employment. The organization offered another excellent program called the wellness recovery action plan. These programs assisted me in my personal growth and gave me a support system in every area of my life, and because I was in a 12-step program, they worked so well together.

The next step was a program called peer resources. This gave me a better insight into communication skills. Applied suicide intervention skills training was an intense program that involved more communication skills designed to help all caregivers become more comfortable, competent and confident when dealing with persons at risk of suicide.

I began employment as a warm line support worker, and I found a gratifying purpose. I have never felt this way before. To be able to use the training had made me more effective with callers who presented problems. I work with 10 other staff who have experience with mental illnesses who wholeheartedly give of themselves. I have much respect for these individuals. Some of them have been working since the warm line's inception. In the spring of 2009, I became the warm line coordinator.

The Canadian Mental Health Association, Sudbury-Manitoulin Branch, started up its warm line program in 2000 with the support of the Ontario Trillium Foundation, and later used the restructuring of another program to find ongoing financial resources. With the assistance of United Way funds, the program also added weekend hours for this past year. Operating seven days a week from 6 o'clock to 10 p.m., the warm line provides support during the time when many community mental health services are closed. We are uncertain if United Way will continue to fund us for weekends.

The warm line receives an average of 15 to 20 calls per evening, with many repeat callers and a higher volume of callers during the winter months. While based in Sudbury, this warm line receives calls from across Ontario and as far away as New Brunswick and British Columbia. I've explained in a recent Network Magazine article that the Sudbury warm line's popularity is due to its reputation for providing real support: "They say that at the Sudbury warm line, the people listen. There's more empathy, more of a personal touch, and that we are focused on them, the caller."

Consumer staff are there to empower callers to make their own decisions about how best to de-escalate their crisis. The goal is to have callers arrive at their own decision as to when and whether to seek help or treatment: "We don't really give advice.... Whatever their crisis may be, we always try to guide [the callers] to come up with their own answers and make their own decisions. We're there to support them through the whole process. When I finish my call, I'm always asking them to call me back tomorrow and let us know how things are going—the follow-up is really important."

The success of Sudbury's warm line is rooted in the peer support model: "I think the most important thing about a warm line is that it's run by consumers.... The callers know that the person on the phone can empathize

and this may make them more willing to talk about what's going on."

Warm lines, staffed by mental health consumers, are supportive and confidential telephone chat lines used by consumers, their families, members, caregivers and friends. Whether callers are feeling lonely or depressed, facing challenges in their recovery or even experiencing periods of positive change that they wish to share with someone, there is an empathetic voice on the other end of the line who is trained in active listening and there to offer emotional support. Information and referrals to other community programs and services may also be provided. Warm lines are proving to be a powerful approach to reducing hospitalization and are decreasing the number of non-crisis calls received by the crisis intervention program.

So to conclude, I was lucky to find the appropriate supports and turn my life around. I was an active IV user; now I am not. I am now a person with lived experience of mental illness and addiction who has a job as a warm line coordinator. I have many friends both at work and in the community, and I have a home. All this was possible because I wanted to be a helper, and as a result, I feel that I am a better person.

Thank you for the opportunity to tell you my story.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Michael.

We've got about 30 seconds left if you wanted to wrap up.

Ms. Marion Quigley: It's okay. We'll wait for any questions.

The Chair (Mr. Kevin Daniel Flynn): There are probably a lot of questions; unfortunately, there's not a lot of time.

Ms. Marion Quigley: I know. We had a lot to say, and we had to read it fast. I couldn't read any faster.

The Chair (Mr. Kevin Daniel Flynn): You did a very good job of your presentation today. Thank you very much. Thank you, Michael.

Mrs. Liz Sandals: Could we just ask one question of clarification?

The Chair (Mr. Kevin Daniel Flynn): Sure—but short.

Mrs. Liz Sandals: The warm line sounds really interesting, but I haven't heard the term before, and I just want to understand what a warm line is. I take it from your remarks that a warm line is sort of a combination of a crisis line and peer support.

Mr. Michael Clark: It's not a crisis line. It's pre-crisis.

Mrs. Liz Sandals: Okay. But it's peer support because the people you will get to talk to are people who have lived experience of mental health and addiction?

Mr. Michael Clark: As well as the people who are running the line.

Mrs. Liz Sandals: Yes. Okay, thank you for that. Now I know what we're talking about.

Ms. Marion Quigley: There are about five warm lines in the province of Ontario. Progress Place in Toronto was

the first one, so we modelled ours after that. It's always consumers running them.

Ms. Liz Sandals: Okay. Thank you.

The Chair (Mr. Kevin Daniel Flynn): I wouldn't worry about the lack of time for questions. You did a great job in your presentation. You got your point across very clearly. Thank you.

CINDY ROBIN

The Chair (Mr. Kevin Daniel Flynn): Our next speaker this morning at 10 o'clock is Cindy Robin. Cindy, if you'd like to come forward. Are you all hooked up?

Ms. Cindy Robin: No. I was hooked up, but I had to unhook—

The Chair (Mr. Kevin Daniel Flynn): You got unhooked.

Ms. Cindy Robin: Hopefully that will happen quickly—

The Chair (Mr. Kevin Daniel Flynn): We'll give you some help too.

Ms. Cindy Robin: —and it won't eat into my 20 minutes.

The Chair (Mr. Kevin Daniel Flynn): Hey, I'm not that mean.

Ms. Cindy Robin: While I'm just hooking this up, I'm noticing that you folks have been sitting still for quite some time. If anybody needs to get up and stretch, please go ahead and feel welcome to.

Interjections.

The Chair (Mr. Kevin Daniel Flynn): Okay, Cindy, are you all set?

Ms. Cindy Robin: No. Actually, I had everything all set up there, but somehow from that plug to this plug it's scrambled itself, so I'm having to reboot it from scratch.

1010

The Chair (Mr. Kevin Daniel Flynn): Okay.

Ms. Cindy Robin: It's just going to take a couple of minutes. Sorry about that.

Ms. Liz Sandals: We can read along here on the hard copy.

Ms. Cindy Robin: I'd like to do my PowerPoint if I can, just for simplicity's sake, because if I start with paper, then I'm not going to notice when this boots up, and I have to do some clicking to boot this up. We're almost there.

Oh, there we go. I was just going to give up and go by paper.

Welcome, folks. My name is Cindy Robin, and I'm a concurrent disorders worker with the mood and anxiety program at Sudbury Regional Hospital.

Now, you're looking at this slide and you're thinking, "Gee, this has got to be the quickest presentation that we're going to have today," actually, I wanted to start out by just saying thank you to all of you for taking the time to listen to myself and my colleagues and for taking an interest in mental health and addictions.

Before I go to the next slide, I just want to find out if folks are familiar with the term "concurrent disorder."

The Chair (Mr. Kevin Daniel Flynn): Yes, I think we all are.

Ms. Cindy Robin: Okay, wonderful. So I'm not going to go through that definition.

Folks, I'm sure, are also aware that within the category of concurrent disorders there are a lot of different people from all walks of life. Everybody know that song, "These are the people in your neighbourhood" from Sesame Street? We're looking at folks all over our community, as well as folks who are marginalized and living in poverty.

There are very high rates of concurrent disorders in the population. In one of the studies that's summarized in a document that has been published by Health Canada, 28.8% of the general population was found to qualify for having a concurrent disorder. That's more than two out of 10. Statistically, even if you look at this room, how many folks—do the math—would be potentially someone with a concurrent disorder? The rates are higher among those who seek treatment. I see folks who are seeking treatment. That's my area.

Another study in the document for concurrent disorders showed that 77% of people who were seeking help for an alcohol problem also qualified for a psychiatric diagnosis.

So the research has been done. The most effective approach for folks with concurrent disorders is integrated practice. Integrated practice, at its bare bones, is treating both the mental health issue and the substance use issue.

I'm going to tell you a little bit about myself and my viewpoint. Like I said, I'm the concurrent disorders worker with the mood and anxiety program. This is a new position for me, but I've been doing concurrent disorders work much longer. I come from the outpatient addictions and gambling services program with the hospital. We were formerly Pinegate, and then we became part of Sudbury Regional Hospital. So I'm a witness to the integration of mental health and addictions programs. All of these programs were scattered in different places throughout the community, and they all came together under one roof at 127 Cedar Street, which is our outpatient mental health and addictions treatment centre.

I formerly worked at John Howard Society, had some grassroots experience, and before that I was a counsellor for students at Conestoga College with mental health issues: stress, depression, anxiety and so on. I studied here in Sudbury and also in Waterloo, and I specialized in addictions when I finished my master of social work degree.

I resurrected the concurrent recovery group in 2007. I didn't do this alone. Actually, one of my partners in crime is sitting in the audience here, Lorie Bell, and she'll be presenting to you I think around 2 o'clock this afternoon. It's not a new group that I resurrected. However, when I left the community it had been running, and when I came back and was hired on by the hospital—by Pinegate at the time—it wasn't in the community any

more. That really saddened me, because I've been personally touched by folks in the community who have had concurrent disorders and have been in recovery.

One that stands out in my mind is a young woman whose name is Leslie. I won't give out her last name out of respect for the family. Leslie was in recovery for addiction and she also had a diagnosis of bipolar. She was a gorgeous, talented, compassionate, beautiful young woman and a dear friend. At the age of 28 years old, she put a needle in her arm and she overdosed. It was a huge loss to the community.

Leslie was the kind of person who just lived life to the fullest. You would see her and she would have purple paint all over her hands because she was making clay masks, and if she ran into somebody on the street, a bum on the street who was drunk, she would say, "Would you like help getting to detox?" and she would accompany him in a taxicab. She did achieve two years of sobriety but had a slip, and relapse is part of the recovery process.

She's one of my inspirations, and there are others in the community as well. So I just love seeing folks like our last speaker, Mike Clark. He's also a dear friend of mine. The amount of good that he does in the community is immeasurable. Most of it is anonymous, so there are no records of it, but I know from the folks I work with that he's making a huge difference.

The information that I'm going to be giving you isn't going to be at a management, executive, administrative level. It's from the viewpoint of a front-line counsellor and a citizen in the community. The folks that I work with individually generally all have concurrent disorders, and the group I've been running for the past few years involves folks with concurrent disorders. So the viewpoints that I'm sharing are coming from witnessing their lives and their struggles and their triumphs.

One of the important things to me was to change the name of the "concurrent disorders group" to "concurrent recovery group." Just take a moment and imagine that you're going in to see the doctor, and the doctor tells you that you have two disorders. You leave. How do you feel? Probably not so great, right? Probably worried, perhaps negative, discouraged. Now you go to see your doctor and your doctor tells you you're in recovery for two things. How do you feel? You feel a little bit more hopeful. So a big piece is nurturing and engendering hope in folks.

With the concurrent recovery group, of course, the aim is to provide integrated treatment, which has been shown to be the most effective type of treatment for these folks. It's a strength-based, self-empowerment structure which involves elements of collaborative therapy and solution-focused therapy. There's a skill-building component, narrative therapy and cognitive behavioural therapy. In its present form, there's co-facilitation between an addictions counsellor and a counsellor from the mental health program.

1020

What I've learned from folks is that mental health services and addiction services are very necessary. There

are lots of folks who want treatment, but it needs to be done in a respectful way. I've also learned that mental health and substance problems interact, and you need to treat them both.

I had it explained to me by a client that it's like a giant iceberg. For this client, the addiction problem was just the tip of the iceberg, the part that you see, and underneath was his depression. If he were to be well, he could be camped out right in the middle of the liquor store and he wouldn't drink, but if he was unwell and his mental illness was in a bad way, then he could be in the middle of the woods and he would find liquor and have a relapse. So they're very much intermingled.

Think of all the negative things that you've heard about folks with mental illness. Now, think about all the negative things you've heard about folks who have substance use disorders. Take all those comments and multiply them and you can get an inkling of what it's like to have double the stigma. To defeat stigma we need opportunities like this. We need to openly discuss mental health and addiction issues. We need to see the person and not the diagnosis, and provide treatment, education, supports and awareness. You'll notice in my handout—I don't actually have "treatment" on the slide. Treatment is huge and it's one of my main points.

I've seen, in the group and with my individual work with folks, a lot of strengths in people. These are folks who have various skills. They're very resourceful, extremely creative people. The non-judgmental empathy that I see in my group really touches your heart. There's a great capacity for joy. There's also a great capacity for pain, resilience, insight and hope.

I find, just looking at that insight one, that ordinary folks who don't have both a mental issue and a substance use disorder generally don't have to work on themselves as hard as folks who are dealing with these two things. What happens is, you have folks who really do a lot of deep digging into who they are. It's just amazing the amount of insight that folks gain. You'll find folks have intellectual curiosity, varying levels of education, wisdom, spirituality, self-awareness, compassion and respect.

My key theme that I want to bring out is the theme of untapped potential. When we, as a society, do not provide the treatment, services and supports that persons in concurrent recovery need, then we diminish their quality of life and we face an immeasurable loss of untapped human potential.

There are a lot of barriers to maximizing wellness, and you're going to hear about these throughout the day. We've heard from the earlier presenters about long wait times for treatment. Because I'm one of the people who provides treatment, that is very frustrating for me. I want to get to people right away. As soon as they phone in and say, "I want to do something about my addiction and mental health issue," I don't want them to have to wait two or three months. We need quality treatment, integrated treatment and funding for that.

There's also limited access to integrated residential treatment. We have to remember that residential

treatment isn't the magic bullet. It's very important for many folks to attend a residential treatment facility, but that's only one part of the treatment process. You also need to have the follow-up. You need to have the aftercare. You need to have maintenance programs that will help folks to continue in their changed lifestyle. Simply going for 30 days to a treatment centre and then coming out isn't enough.

Other barriers that I see are just the basic needs: poverty, housing, safety, security. When I have someone who has a concurrent disorder and they have a room in a home where people are abusing substances and partying, and this individual knows it's important for their mental health that they abstain, it's nearly impossible for them to achieve that goal being in that environment. When I think of housing, I'm thinking of private units that are clean so somebody can create their sanctuary for themselves. It doesn't have to be huge, but it needs to be clean and it needs to be safe.

There are numerous psychosocial stressors that my folks go through, and lack of supports. There's insufficient access to psychiatric care and frustrations about medications—folks sometimes feel like guinea pigs because they have to try different medications and find out which ones work, but they tend to bear with that because they know they need to—lack of medical care and stigma within medicine, lack of adaptive employment and educational opportunities, with some really brilliant exceptions like the warm line with CMHA.

There's a lack of accommodation for these folks. Sometimes places will be very accommodating for the more popular disabilities. However, because there's so much stigma attached to mental health and addiction, there's less accommodation in the workplace and in the education system. And then folks tend to blame themselves for the lack of a supportive environment: "I'm not reaching my potential; therefore I am inadequate. It's my fault."

More struggles—I'm going to breeze through these because I want to make sure I touch on what I need to touch on. When we're looking at healing, we're looking at assessment, including assessment for the addiction issues and mental health. We're looking at designing a treatment plan. We're looking at withdrawal management in many cases, individual and group therapy, education and skill-building. Knowledge is power.

We're looking, in many cases, at trauma treatment. A lot of my folks have been through indescribable trauma and abuse. So that is a piece of the puzzle in terms of making things better. With that trauma, there's a lot of self-blame that is part and parcel of the psychological repercussions of having been victimized.

Recreating leisure, feeling and facing emotions, embracing success and building healthy supports—so, witnessing the uniting of mental health and addictions under one roof, I've been able to see a lot of things that are working. Integration has provided access for addiction clients to psychiatrists. That's huge. We've also been able to put clients into the mental health groups. So my

addiction clients have been able to go to bipolar groups, social anxiety groups.

We've had service-wide initiatives. At Christmastime, at holiday time, it's very difficult for folks, so we opened it up to all of the clients with mental health and addiction issues to come to that. The holistic, multi-disciplinary approach provides what folks need.

I'm just skipping through this. Also, interorganizational collaboration has been really helpful. A lot of my folks benefit from use of the self-support groups, like Alcoholics Anonymous, and there is more of an openness now than there was in times past. With these self-support groups, they used to sometimes say, "You can't be taking your medication for mental health. That means you're using; you're relapsing." Because there are brave folks like Mr. Clark, who just spoke with you folks, who do open up about it now, the stigma is going down and folks are having that opportunity to share about it.

Effective treatment needs to be tailored to attack both the addiction problems and the mental health needs and to be uniquely tailored to the individual and their stage of readiness for change. So my request is for more funding for quality integrated treatment. There are effective treatments that work—the evidence shows it—and folks want treatment. We've got hundreds and hundreds of people on our waiting list, and we're not able to get to them because we just simply don't have enough counsellors.

1030

The other asks that I'm putting out there are reducing wait times for folks who are seeking outpatient treatment for addictions and mental health, and then housing, which isn't my game; however, just working with my folks and seeing what they need, clean, private housing is huge. Also, increased access to residential treatment that involves integrated services. There are residential treatment centres. There's the Iris centre up here in the north; there's Nipissing treatment centre. We need more support and more funding initiatives for integrated treatment, both in the outpatient realm and in the residential treatment realm.

That winds me up, so thank you very much for your time and attention.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much. That was good timing; you just ended on the beep.

Ms. Cindy Robin: I have this little clock up here at the top of the screen, so that kind of helped me a little bit.

The Chair (Mr. Kevin Daniel Flynn): That's perfect. Well, thank you very much for coming this morning. We really appreciate your presentation.

Ms. Cindy Robin: You're welcome.

The Chair (Mr. Kevin Daniel Flynn): I think you were very clear, and thanks for your time.

SOCIAL PLANNING COUNCIL OF SUDBURY

The Chair (Mr. Kevin Daniel Flynn): Our next speaker this morning is Janet Gasparini from the Social

Planning Council of Sudbury. Janet, you've got 20 minutes; use it any way you see fit. If there is time at the end, we'll split it amongst the members for discussion.

Ms. Janet Gasparini: Perfect. Thank you, and thank you for coming to Sudbury. My name is Janet Gasparini and I'm the executive director of the social planning council here in Sudbury.

If you don't know, social planning councils are non-profit, charitable organizations that exist in some communities in Ontario and have a mandate for social research and community development in terms of social issues. So when the notice came that you were going to come to Sudbury, my office was notified and, as we often do, we convened a community consultation with a number of our partners so that we could talk about the report *Every Door Is the Right Door* that was put out by the Ministry of Health, have a look at it, and then I could come as a representative of that group and tell you what we talked about. So last Friday we met, and I have to tell you that there was very keen interest and that we had over 30 community partners come together to talk. It included people from the police department, from public health, front-line workers and families of people who were struggling with mental illness and addictions. The friendship centre was there; the Shkagamik-Kwe Health Centre was there. Mardi and her staff from the action centre, from whom you heard a brilliant presentation, were there. Three of the four school boards in the area were there.

It was a testament to the fact that mental health and addictions issues cross all of those boundaries, that we are struggling with the impact and the effects of mental health and addictions anywhere that we work in community. So it's exciting to have an opportunity to talk about what we need, not only from the Ministry of Health but from the government of Ontario, in crossing all of those barriers and boundaries and making it easy for us to work in community in an integrated fashion. We're actually very good at that, at community, when we're given the tools, the resources and the capacity to do it, and I'm going to give you some examples and hopefully some information about how we might implement this in a more effective way on the ground.

I'm going to give you just some of the feedback from the group. We did a little PowerPoint presentation. They all got the document ahead of time. We went through the basic premises of the document, and overall, people were very impressed—

The Chair (Mr. Kevin Daniel Flynn): I'm going to jump in there just for a second, Janet. Just so you don't feel sort of confined, the report was issued by the minister's advisory group. There's been some confusion as we've been travelling around; some people think we are the minister's advisory group, and we're not. So don't feel confined—you can talk about the report, but you don't have to only talk about the report. You can talk about anything you want.

Ms. Janet Gasparini: No, we realize that in fact it was not your report, but we thought it was a very good

stepping stone, right? We think the report is good. We thought it provided a very good basis for the conversation, a good place to start. So rather than talk about all the issues—and I went to the website and read a lot of the feedback that you're getting at the panel. You're hearing from survivors; you're hearing from mental health workers; you're hearing all the things you need to hear.

What we wanted to bring to you was a community approach around how to do integrated service delivery, because for us, it's a given that that would be the way we go. It would be an integrated service delivery model. We've used it in other areas and we know that it's effective. So for us, it was a good starting point, as opposed to just, in general, what are people concerned about in terms of mental health? I think you're getting a good sense of that as you travel across the province. What we wanted to focus on was what, in fact, would happen in a community if that document became the basis of the government's strategy. So I'm aware that you're a different group, but we still thought that was a good place to start.

The Chair (Mr. Kevin Daniel Flynn): We're still nice people.

Ms. Janet Gasparini: You're still very nice people; absolutely.

We talked a lot about what was in the document, and there was strong support for what was in the document. Of course, there was talk about what isn't in the document and what needs to happen to make the document come to life.

We had a good conversation about the stigma that people suffer, and I know you've heard lots of that. Different than what you might have heard, in this group, anyway, there was lots of talk about starting the education, the training and the stigma reduction very early in life. We had a member of the group who was a family member and she said, "Forget about trying to change the 50- or 60-year-old guy's mind. He's going to think, 'He's a bum. He's always going to be a bum. He's never going to change.'" But let's work with our children in the school system to help them understand, when one of their buddies' behaviour is off, what that means. What's that about? How do you talk to your parents? How do you talk to a teacher about, "I don't know why Susie's doing this. Susie didn't do this yesterday," and really start having people and children understand, so that as they become the next generation, we've done something about reducing the stigma? It's not to say that poster campaigns and that kind of work isn't important, but a real difference in the education system around, what are our children learning in schools and how easily identifiable are mental illness issues? Are we talking about them at school so that we make it safe for children to understand them?

There were lots of suggestions about using multimedia, the new tools, Facebook, Twitter, things that I'm really having a time wrapping my brain around. How do we become educated in those modalities and start using them? Television programs that educate—in some of the

stuff that comes out now in the States, they'll have a psychologist work with somebody who's hoarding in their house. They take you into their house and they show you the hoarding. I think that kind of stuff is doing more to educate people, because, "Jeez, I've got a friend and her house looks like that," you know? "I didn't know that was something we were supposed to help people with." Or, "My house looks like that. Maybe I'm supposed to get help." That kind of initiative, a very broad-based initiative, we thought was important.

Mr. Bas Balkissoon: That's my house.

Mr. Jeff Leal: We've got one.

Ms. Janet Gasparini: Sorry if—I know the two in 10, but maybe that's me.

We talked a lot about treatment. We had front-line workers, and I think a lot of what you've heard and a lot of the conversation was that the strategy has to be balanced between effective treatment and prevention, that we can't put all our eggs in either/or baskets. Typically, in what I lovingly call our disease care system—because we really don't have a health care system, right?—all of our energy and our attention is on disease. In our current system, we do lots when people get sick and we want to make them better. We don't do enough in the upfront. There has to be better balance.

Of course, you can't just move resources to prevention, because people still need treatment. When a person in your family is sick and you're at the hospital and you're demanding treatment, that's what you want. So it might mean that we have to make extra investments in the upfront until we can start to see the benefits of those investments down the line and see our calls and our need for treatment, which is a much more expensive end of things, reduced. There will have to be some lag time in doing that.

We talked about the need for immediacy of service response, real-time response, being able to meet people where they're at, being able to have mental health workers in schools dealing with young people today, not three months from now when we can get to them, because three months from now it will be way too late—and, particularly around children's and young people's mental health issues, being able to differentiate between behavioural issues, mental illness and things that need therapeutic intervention. There's some concern in our child mental health system about workers being caught up dealing with young people who have behavioural issues that really aren't about mental illness, yet there's no real way in the system of differentiating that. So we're using our very precious mental health resources dealing with issues that aren't mental health, and then the child who is having their first psychotic episode or first schizophrenic episode is being somehow missed in the system because other things are taking that place—so really being able to move between those two. The therapeutic treatment must be evidence-based, that people are appropriately trained and that there's a real attention to cultural awareness; more and more urban aboriginal folk are coming into Sudbury, so making sure that we've got people who are addressing that in an appropriate way.

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I talked about other modalities of addiction treatment other than residential programs, and you heard a little bit about that, so being able to talk about intensive day therapy and those kinds of things, and a very family-centred approach to the whole system. A doctor is not treating a person, they're treating somebody who's in the midst of a family, and the whole family is involved and integrated and suffering when you're working with one person with mental illness.

Some of the gaps that they thought were in the framework, and that I guess would be gaps for you folks to think about, were that there really was not a lot of recognition of the results of childhood trauma—so, sexual abuse and domestic violence—and lots of evidence that adults move into the system with those issues never recognized, treated and acknowledged as children—and then, as adults, not being able to function. We've got a particular program that was developed by one of our Ontario Works workers here working with very hard-to-place male cases, and we just got some money from, I think, the Attorney General to set up a special sexual abuse program for males, an area that we've not paid any attention to. We've moved into providing treatment for women in terms of sexual abuse, but really we've ignored that whole arena. When you looked at the stats of this particular Ontario Works caseworker who only dealt with difficult-to-deal-with men—guys who just weren't getting jobs, weren't getting off the system and weren't doing well—when they did psychometric testing, 98% of them were survivors of sexual abuse as children. If we're not paying attention to that in the earliest of stages and then as adults, those problems aren't going to be fixed.

You heard a little bit this morning about primary care. First of all, please don't make any assumptions that anybody has access to primary care if they've got a mental health issue; doctors don't and won't take on clients. Part of that—and I don't think it's that doctors are bad; I think it's because the system pays doctors in a particular way. If you're going to have to take 45 minutes with a client and that's going to be a \$17 visit, it's not going to work for you, right? So something has to happen around primary care and access to primary care. I think the direction of family health teams and nurse practitioners and the things that we're starting to see evolve are good responses. Especially here in the north, more than 70% of the people with mental illness don't have access to family doctors, so you can't assume that's going to be your first line of treatment.

Another area that they talked about that they didn't see in the strategy was women in the postpartum period suffering from depression and how important it was to have the proper interventions. We do have a very unique program in Sudbury—I actually think you're going to hear about it later today—making sure that's accessible. If that bond between mother and baby doesn't happen in those first stages, again, there are lifetime ramifications not unlike sexual abuse and domestic violence. We've got to make sure, if a mom doesn't do well in the post-

partum period, that immediately there are resources in place to make sure that those things are taken care of.

Locally, what the group talked about was the fact that in terms of child psychiatry in the north we are in big, big trouble. We had a school board superintendent who talked about not having been able to access a child psychiatrist in seven years for any of the referrals from their board—so, child psychiatry and the mechanisms to get access. Of course, it's a very refined specialty. We have a number of psychiatrists in Sudbury, but a psychiatrist who's not registered to practise child psychiatry can't just take those children on. That's a real gap here in the north.

We talked a lot about what it would take to build this integrated system and how we would address that in the community. It goes right down to the importance of those healthy early years and the parenting strategies. Whereas the Ministry of Health is concerned with illness and disease treatment and maybe some health promotion and prevention, what we would like to suggest is that the Ministry of Health has to be just as concerned with what you're doing over in children and youth services and MCSS in terms of Best Start programming and making sure that that baby—I'll tell you my little personal story, because I love to tell it.

My first job in the world was nursing; I figured out how hard that was and I stopped doing that. I worked on the maternity floor and I would work with moms and their babies and send them home from the hospital. At one point, we were getting about a day and a half to work with the moms and babies because the movement was to get mothers home really quickly. I would work with moms who had absolutely no clue what they were doing with this baby. They had not been parented well and they had no support systems. I remember dressing this little boy, and I had tried so hard with his mom and I just couldn't get her—going out for the cigarette was more important than the feeding. But the family was there and they were excited to bring this new toy home. I was dressing the baby in the nursery and I was crying. I thought, "I should just go down the back stairs and take this baby away because in two years, this baby will be a mess"—not because these were bad people; they were excited to be bringing this baby home. They just had no clue what they were supposed to do with this baby once they got him home, and so the damage begins.

I've had a mantra since then in the community work that I do that mom needs to be taken to the community hub, the Best Start hub, on her way home from the hospital, where she gets a massage and baby gets taken care of and all of that support network is put in place, so that there isn't a day that mom has to think about, "What do I do with this baby?" and not be able to ask for help.

To take your strategy that far back and notice the difference it would make if every single baby who was born in our communities had the kind of care, supports and resources around them in that newborn period, we would alleviate so many of the issues that we struggle with down the road.

We talked about the importance of the early years. We talked about training for those who aren't necessarily front-line workers. We had police officers at the meeting. The police and the jail system is the most expensive mental health work we do. We pay police officers a lot of money. We have them tied up at the emergency ward at the general hospital or at St. Joseph's Health Centre here guarding people with mental illness instead of being out on the street fighting and preventing crime. We have to somehow figure out how you shift that, how that doesn't become the police's job, and that when it becomes the police's job, when a person is actually a danger to themselves and others, the police have the proper training, that they're doing that right and it's not just about picking somebody up and throwing them in jail because their behaviour was odd.

The same is true of teachers and educational assistants and all of these people who work front-line who are going to become engaged with people who are suffering from mental health and addictions but maybe don't have the proper training. How do we build that system, not that they become the counsellor but that they become aware and connected to the services so that the proper things can be put in place?

We talked a lot about streamlining the process for access to the system, and I think you've heard about that. I can tell you that the people around the table who are not front-line health workers are eager to be involved in this process. Front-line workers in our homelessness network, for instance, are very aware of what has to happen and how to make those connections. We've done some good work in Sudbury around making that happen, but we have to have the structures and resources in place so that it's an easy link between a front-line streetwalker—Mardi talked about the needle exchange people. The needle exchange person might be your best access to what the next step is. But we need to make sure that the infrastructure is there so that that can happen in an easy and fluid way. If that's the person whom the addict is trusting, then let's make sure that that person has access to what they need to bring the person to the next stages.

Lots of people talked about first things first, that if we don't meet the basic needs of people, if they're not in safe housing—safe housing, you will hear over and over again—there's not even any point in sending them on for treatment, because you can go to your treatment and go to your group and then you're back out on the street. What good was that? Again, it's about the Ministry of Health influencing—you're not going to pay for housing, but you've got to be at the table with the Ministry of Municipal Affairs and Housing and really supporting and making sure that the resources are being delivered. Ultimately, as politicians, you set the overall budget for the province of Ontario. Stuff should not get in that budget unless there's a way that it's linked, unless there's a way that housing and the supports that are needed in housing and your mental health strategy are linked in the politicians' minds, in the budget and in the government's mind. If they're not, then they shouldn't get through the

budget process because it's not going to work on the ground and in the community.

We had people talk about very experienced and qualified counsellors and mental health workers taking care of things that they shouldn't be taking care of. If they're busy on the phone trying to find housing for somebody, that's not a good use of their time. The links and connections have to be made to the front-line housing workers so the front-line housing worker can find housing, but they can also be in touch with the counsellor and make sure that that next stage has happened.

We're ready in the community to do those things. We've got some great examples of how we've done them. What we need at the ministry level is flexibility and fluidity between your ministries so that somebody can say, "You know what? There is a chunk of our funding here that we can actually use." A program like Mardi's, which will be lost—it blows my mind when we hear about a warm line being funded by the United Way. Where else in the health care system—do we fund emergency departments at night with United Way funds? We'd never dream of doing that. Why do we think that's okay in terms of mental health? It's not okay. So we've got to raise that up to the level and make sure that the system is complete and robust. And it's not just the Ministry of Health's job; it has to be an integrated model between all of the ministries.

1050

Getting to housing is important. I wasn't here back in the 1980s—I was working as a nurse—but somebody who had been in the system a long time said that back in the 1980s, we actually had a good system that worked. We dismantled it and now we're starting over. So maybe the advice is: Go back to look at whatever it was we were doing in the 1980s and let's do it over again.

The Chair (Mr. Kevin Daniel Flynn): I was disco dancing.

Ms. Janet Gasparini: Me too.

How much time do I have, because I don't have—

The Chair (Mr. Kevin Daniel Flynn): I think you've got about three minutes—two minutes, actually. Sorry.

Ms. Janet Gasparini: I do want to leave you a little bit of time for questions. I think I've actually made most of the points that the group made. We're ready, in community, to provide an integrated system. Our police departments, our schools, our child care providers—we're ready to work together. What we need is the capacity delivered in an interministerial way to make that happen.

I'll stop there so that you can ask questions if you have any.

The Chair (Mr. Kevin Daniel Flynn): You've left probably time for one question. Maria?

Mrs. Maria Van Bommel: I was really interested in everything you said.

Ms. Janet Gasparini: Good.

Mrs. Maria Van Bommel: It was very excellent. But I want to go back to the parenting. As parliamentary assistant for the Ministry of Children and Youth Services,

parenting is something, of course, in the Early Years and the Best Start—Best Start, especially, is close to my heart. One of the things that we keep seeing, though, repeatedly—and it is exactly what you're talking about—is the young parents who, no matter what courses and what programs we put forward, don't take advantage of them. We have other parents who, if we hid the programs under bushel baskets all over the countryside, would find them anyway. But there is that group of parents who never seem to take advantage, and yet they're probably the ones who need it the most.

How do you suggest we can access—because, like you said, it's almost like you want to take them and force them to—

Ms. Janet Gasparini: No, and you can't do that.

Mrs. Maria Van Bommel: —but their civil rights would say, "You can't do that," right?

Ms. Janet Gasparini: That's right. What we've done in our Best Start network in Sudbury—and if you've got extra time at the end of the day, I'd love to let you know what we've done in Sudbury, because, as you know, their funding came from the feds and then got cut off, and so some got out and not all. But what we did in Sudbury is, we had already started a Best Start network, which included all of those partners that I talked about, and had started to plan for what we would do in Best Start. Even when the funding stopped, we said, "Well, we're not stopping," because the bottom line was: There was about \$30 million coming into Sudbury in terms of early years development, including schools and public health and what not, and we kept that table together.

We have opened 13 Best Start hubs in schools in our community. Our public health unit is a part of that network. As a baby is born in the hospital and it is recognized that there could be—so they're sent to public health for a home care visit. The home care visitor is in the house. The home care visitor is encouraging the connections at the Best Start hub and encouraging the mom to come. So you're right; we can't make them come, but making sure we've utilized all of the players in the system in the most effective way.

If the health care people were out here and didn't know about Best Start and weren't connected to Best Start and daycare and going to see the mom and bringing her all the great health unit publications, we'd be missing the boat, because all the pamphlets in the world are not what's going to get that mom in, but coming and building a relationship and saying, "Why don't you come with me down the street?"—that's the avenue we've taken and that's the work we're trying to do.

Those are the examples of how we need to be able to work in community, and that takes flexibility and some resources. We didn't get new resources for Best Start. We used the \$30 million we had much more effectively. Let us do that with mental health.

The Chair (Mr. Kevin Daniel Flynn): We have time for—actually, we're out of time. I took some of your time with my stupid joke. Sylvia, just a brief question and answer.

Ms. Sylvia Jones: Just a really quick question. You've done an excellent job of bringing the points of a number of agencies forward. Maybe I'm one of the unlucky ones. I am not familiar with the social planning council. Obviously, we don't have one in my area.

Ms. Janet Gasparini: Well, you should. We could have another hearing on that.

Ms. Sylvia Jones: Social like it. Where's your funding coming from?

Ms. Janet Gasparini: Social planning councils get funded—there are about 17 of us in the province, and it's different in every community. In this community, we are well supported by the municipality. United Way is our funder, and Trillium project finding. But we have worked tirelessly with a number of ministries, and every ministry we visit says, "It's great work. We should have one of you in every community, but you don't come under our bailiwick." So we struggle.

Across the province, in terms of the poverty reduction strategy, it was social planning councils across the province that motivated people in 30 communities to meet with their MPPs. In communities where we didn't have a social planning council, we sent social planners in.

Ms. Sylvia Jones: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Janet. Thank you very much for coming today. You did a great job.

Ms. Janet Gasparini: Thank you very much.

SHERI JOHNSON PURDEN

The Chair (Mr. Kevin Daniel Flynn): Our next presenter this morning is Sheri Johnson Purden. Thank you for coming.

Ms. Sheri Johnson Purden: Thank you for having me.

The Chair (Mr. Kevin Daniel Flynn): You're welcome. Make yourself comfortable. There's still a clean glass and water there, I think, if you need any. Everybody is getting 20 minutes this morning, and if you leave some time at the end for some questions, that would be great, but that's entirely up to you.

Ms. Sheri Johnson Purden: I just want to let you know that I'm very thankful that I have this opportunity to speak with you on behalf of the mothers who are suffering from postpartum depression or perinatal mood disorders. I believe that it is something that is very much missed in the mental health system and needs a lot of attention. So with that, I'll start.

I come before you as a person from the community to share my experiences and knowledge about the changes that are needed to help out families within the north. Up to 20% of families begin their journey of parenthood with perinatal mood disorders. I myself have travelled this journey with three daughters. I never knew that the birth of my children would lead me on such a path of advocacy for other families.

I have facilitated the peer support group called Healthy Options Providing Effective Support, HOPES,

for the last 12 years. I have spoken at many conferences across the province on my experiences and have been a member of several different provincial advisory groups for perinatal mood disorders.

I have also been interviewed by many magazines and newspapers and had my story published within the CAMH postpartum depression guide for front-line health care and social service providers. I have actively participated in research projects with Laurentian University's School of Nursing with Dr. Phyllis Montgomery and school social work professor Dr. Carol Kauppi.

Recently, I have been employed with the Canadian Mental Health Association's Sudbury-Manitoulin branch on a project funded by the Ontario Trillium Foundation. The project involves the gathering of information for the creation of a peer support program for mothers with perinatal mood disorders. I have gained insight on how the mental health system works compared to the physical health system—each system separated for the treatment process. If I am not well, should I not have access to a health care provider regardless of my illness?

I will speak to you today on the treatment of mothers with perinatal mood disorders and what needs to be in place to help out the families and society as a whole. I believe that perinatal mood disorder treatment can be a door for many to become healthy without going through the needless pain and suffering that mental illness can cause.

In my experience, mothers with perinatal mood disorders are more conscious of mental illness within their children, should it occur. If their child complains of headaches, stomach pains, nausea and fatigue for long periods of time, the parent is able to advocate for their child for mental health services.

If, on the other hand, the mother doesn't get diagnosed and treated for perinatal mood disorders, her children will have behaviours related to attachment disorder. This leads the children to low self-esteem and addictive behaviours, some leading to criminal activity. I think that we owe society the input of funding towards helping out mothers with perinatal mood disorders.

There has been a great deal of progress within the province with regard to perinatal mood disorders since I first suffered with my daughter 14 years ago. The investment of the province in early years centres, now known as Best Start hubs, is a great relief to many families that need a place to socialize. The perinatal mental health program at the Sudbury Regional Hospital is instrumental in helping out mothers in the greater city of Sudbury. The ability of mothers who are not well and must be hospitalized to have access to their babies during the day is another step.

All of these initiatives are wonderful. We are lucky in Sudbury to have such access to these services, but there is room for improvement.

With my first experience of a perinatal mood disorder, I did not know that my world was so distorted with the illness that I would turn away family and friends and isolate myself in my own little world, where everything

was bleak and horrible. It was myself who would ask the family doctor about it and have him hand me medication. I would then begin to tell my family about my illness of postpartum depression.

My ability to speak out without fear of repercussions from my peers placed me in a play group that had a six-month waiting list. This play group at Jubilee Heritage Family Resources was my saving grace. The staff encouraged me to participate in the different workshops as they provided child care for me.

1100

The Chair (Mr. Kevin Daniel Flynn): Do you want to take a little break?

Ms. Sheri Johnson Purden: No, I'm good.

The Chair (Mr. Kevin Daniel Flynn): Are you sure? You have a pile of Kleenex next to you.

Ms. Sheri Johnson Purden: The staff encouraged me to participate in the different workshops as they provided child care for me. They then encouraged me to become a part of different committees related to the resource centre. They introduced me to other mothers who had been suffering with postpartum depression as well. This is why the introduction of the Early Years centres and the Best Start hubs is such a great success.

The Jubilee Heritage Family Resources centre further encouraged me to start up a peer support group for mothers. Although the numbers were low at the beginning, the numbers have grown throughout the years. The Best Start hubs are the best place to hold the peer support meetings, as there are staff available for child care.

Ideally, funding to pay a peer facilitator for the groups would increase the longevity of the groups. I have been facilitating hopes for 12 years as a volunteer. This is not the norm. I have had many supporters who have tried to begin peer support groups within their communities but needed to return to work, as the demands of raising a young family are very high. The mothers usually discontinue their role for the peer support groups. Many mothers are faced with other barriers to participation. Some are unable to come due to child care and transportation issues. This is why I believe that providing the funding to the Best Start hubs for peer support meetings is instrumental in helping our children have a brighter future.

Along my journey, I've had many people call me to help them through the health system to obtain services. Many of them will visit the crisis department, leading them to the emergency department. It is very disturbing to watch these mothers have to qualify their illness through the system in order to see a doctor. When they ask for help at the emergency, if they are not ill enough or contemplating suicide, then they do not qualify to see an emergency doctor. Why do the mothers have to be very ill before they get services? It is well known that perinatal mood disorders are very easily treated. If these mothers had a direct contact to go to, they could become healthy rather quickly. These services are needed so mothers can provide care for their infant.

The Sudbury Regional Hospital has a perinatal mental health program that has helped numerous mothers and families. It has given hope to our community that someone is willing to listen and help us. The program has recently had to start a waiting list and re-establish their qualifications for mothers to be treated. Again, we are subject to, "You are not sick enough for services."

We know that perinatal mental health programs work very well with a counsellor and a psychiatrist available for treatment plans. We need to have more of these programs available in the north. I have been working with different organizations within the north to try and establish services for these mothers and their families. Everyone wants one number to call to receive the help they need. I would like to see access to a counsellor and a psychiatrist be made readily available to the families in the north. Southern Ontario has had these programs for years. It is now time to help out the families of the north.

The next situation that I have been witness to is the hospitalization of mothers with perinatal mood disorders. These mothers are looking for comfort and a safe environment when they are ill. I have seen these mothers' anxieties heightened as they visit the emergency department hoping to be led on the road of healing. These mothers are uprooted as a psychiatrist informs them to stay at the psychiatric unit of the hospital. They are to turn in everything they own, including their own babies.

These mothers and their families are frightened as they enter the halls of the psychiatric ward. The babies are not allowed to stay with these mothers due to insurance risks, yet these mothers need to have contact with their babies.

Let's make the situation less stressful for all involved. We need a retreat for these mothers to heal. This home needs to have a peaceful setting with an inviting environment where children and family are welcome and feel welcome. Many of the mothers who are admitted to the psychiatric floor feel very stressed about their babies being in such an environment. The babies are harder to settle in such an environment. The babies need to be with mom in a home. This home should have access to child care providers so if a mom feels stressed, she can call upon them to help her. There should be a common area where the mothers could socialize with one another and slowly be introduced to their parenting role. The father or partner should also be involved in the new role that they have to play. The whole family needs to learn what will work for them.

We already have a transitional home in Sudbury for those with mental illness. Why can't we do it for families to help the baby on the road to mental health?

These are only a few of my requests to help the system work better for mothers with perinatal mood disorders: peer support groups in the Best Start hubs, a perinatal mental health program for the larger communities in the north to help improve access to the services for families and mothers, and also, for those needing more support, a home where the mothers, with their babies, can go to heal and gain self-confidence in their new roles as mothers.

Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Sheri. You did a great job. You've left quite a bit of time for discussion, which is good, so let's start with either Christine or Sylvia.

Mrs. Christine Elliott: I don't have any questions, but I'd just like to thank you very much for your presentation. It means a lot to us that you were here. Thank you.

Ms. Sheri Johnson Purden: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Sylvia?

Ms. Sylvia Jones: I have also had some experience with the Early Years centre, now renamed. I've seen the advantage of the peer support process. I think it's a great way, as you say, to transition mothers into their new role. Well done for bringing it forward.

The Chair (Mr. Kevin Daniel Flynn): France?

M^{me} France Gélinas: I'd like to continue on this idea of peer support for moms and families. How would you see it working? Where would those peer supports get paid from? Who would they work for? How would they become available? How would that work?

Ms. Sheri Johnson Purden: I would say that within the Best Start hubs, some of the staff members themselves have gone through postpartum depression. So it would just be a matter of redirecting that funding or giving honorariums to a mom who steps up at the Best Start hub and says, "You know what? I think I can do this."

What happens is that when you have a group, there's usually a transition of roles, where someone who's attending the group as a member wants to take on a more direct role and feel like they're actually contributing to helping out families and mothers in the community. So an honorarium system, or some sort of pot of money, needs to be put aside for those moms to pay them, because I've seen moms come and go, and they just don't have the time. They need something to make it more worthwhile for them to do the peer support role.

M^{me} France Gélinas: And they would be tied to the—

Ms. Sheri Johnson Purden: Best Start hubs.

M^{me} France Gélinas: To the hubs.

Ms. Sheri Johnson Purden: Yes.

M^{me} France Gélinas: In our community?

Ms. Sheri Johnson Purden: Yes, because that's where the moms are. The moms are at the hubs. Even when I go to visit the hubs, I know there are moms there who aren't well. They are hiding in the corners and they're not coming out. But if you give them access to something that can, hopefully, pull them out so that they can get the help they need—they are going to the hubs to get out of the home because they don't want to be home. They are afraid to be alone with their babies. They want that socialization.

M^{me} France Gélinas: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Any questions on this side? Liz and then Maria.

Mrs. Liz Sandals: Just to comment, I think the model which you're talking about and which the social planning council folks were describing is actually somewhat unusual in that it has been put out into the community, the

Best Start hubs, and into the schools. A more frequent model is that you'll find that there's one Early Years centre in one large city, or maybe in an entire county there might just be one location.

I'm wondering: In that situation, where the Best Start hub isn't right in the community, how does the mom find out about the Early Years centre? How did you get hooked up with the Early Years centre and Best Start hub? Because it's sometimes that first connection with, "This is where help is." How do you get that first step of the connection?

Ms. Sheri Johnson Purden: For me it was my minister who introduced me to the Jubilee family resource centre.

We have to get public education out there, I think, and direct it towards the families and the partners, because they're the ones who are going to notice the changes first. Those are the ones who will say, "Honey, there's something wrong." The mothers are usually in denial for quite a long time, whereas the fathers or the partners are the ones who take the initiative to get help for them. That's what we've seen through our research, that the mothers heavily weigh upon their partners to take care of them and take on the additional roles. We need to direct some public education towards the fathers and the partners. We are forgetting them. That's what I've noticed. First of all, it was the baby. Everybody pays attention to the baby. Now we're slowly starting to go towards the mom, but we need to include the fathers in there too, because fathers play a very important role in the family of a baby and children, and they should not be discounted.

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Mrs. Liz Sandals: Thank you.

Ms. Sheri Johnson Purden: You're welcome.

Mrs. Liz Sandals: Interesting observation.

The Chair (Mr. Kevin Daniel Flynn): Maria?

Mrs. Maria Van Bommel: Thank you very much. I really appreciate you coming in and telling us about your own personal story. As I said before, I am a very firm believer in the Best Start and Early Years centres. Something that we've noticed in my community—and having a number of grandchildren, I'm following the Best Start as my daughters and daughter-in-law go through those things. In one of the communities, in the hub, they actually have a postpartum depression clinic.

Ms. Sheri Johnson Purden: That would be ideal. That would be absolutely ideal.

Mrs. Maria Van Bommel: Yes, it's right in the hub. And very often, as you say, the mothers don't present themselves. It's because they come to the hub for other services—like you say, for the socialization of the hub—and it's the workers there who identify them and just sort of steer them towards the postpartum clinic. That has worked very well in that community.

One of the things that we have—I have a very rural riding—is the transportation issue.

Ms. Sheri Johnson Purden: Yes, definitely.

Mrs. Maria Van Bommel: It's getting moms to the Best Start, to the Early Years centres. That is because

very often, there may be only one vehicle in the family and it drives off at eight o'clock in the morning to work. Mom is left with all these kids, and she's getting progressively worse and has no way of getting herself out. Like you say, they want to be out, they're actually afraid to be alone, and yet they can't. So how would you handle that in this area, in the north? Because you have even greater distances than we do in southern Ontario and rural areas.

Ms. Sheri Johnson Purden: I would like to see some sort of a transportation system put in place with drivers—and paying for them. I know that here in Sudbury we've tried bus tickets, but you know what? Taking a bus with a newborn baby and toddler is just sometimes the hardest barrier to get over. So if we could have a bus or a van going around to pick up these moms, that would be very helpful for them. I know it's an insurance nightmare, and everything's always a insurance nightmare, but in the long run, the safety of these children and the lives that these children are having—we need to improve them, their outcomes.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Sheri, untreated, what's the outcome of postpartum depression? I mean, obviously you hear about the really tragic outcomes.

Ms. Sheri Johnson Purden: Yes.

The Chair (Mr. Kevin Daniel Flynn): What's, typically, though—it's not treated, the child grows up, the mother moves on. Does it linger, though? Is there a depression that accompanies that?

Ms. Sheri Johnson Purden: If the perinatal mood disorders aren't treated, then it leans towards more chronic illnesses. So the depressed mom will have a chronic depression. In her tending to her own needs and trying to tend to her family needs—they're neglected. Trying to take on the cues of the children and babies, those are really not so readily occurring, because the mother is not able to feel those cues. Ideally, I would like the Best Start hubs to have parenting courses on those cues and how to get those attachments starting to happen, because that first year, from zero to one, is such a crucial time frame for that little baby. It's not as simple as, "Well, let them cry in the crib," anymore. We need to be actively involved with them.

The Chair (Mr. Kevin Daniel Flynn): Okay. Thank you very much for coming today. That was a great presentation.

Ms. Sheri Johnson Purden: Thank you.

The Chair (Mr. Kevin Daniel Flynn): And thanks for what you're doing on a volunteer basis.

NOOJMOWIN TEG HEALTH CENTRE

The Chair (Mr. Kevin Daniel Flynn): Our next speaker today is Barbara Erskine. Barbara, come on forward.

I'm going to let you pronounce your organization, just so I don't mess it up, because I've gone over that a few times in my mind. Do you pronounce the J, or is it silent?

Ms. Barbara Erskine: It's soft, so it's Noojmowin Teg.

The Chair (Mr. Kevin Daniel Flynn): Noojmowin Teg. Thank you.

Ms. Barbara Erskine: Sorry about the delay.

The Chair (Mr. Kevin Daniel Flynn): It's okay.

There you go. Make yourself comfortable. Everybody's getting 20 minutes. Use that any way you see fit. If we have any time at the end, we'll maybe get into a little bit of a discussion. It's all yours. Thanks for coming today.

Ms. Barbara Erskine: Thank you. I'm off to a good start because, as they say in the commercial, "Technology—not my forte." Anyway, I think it's just moving along maybe by itself.

It's my privilege to speak to you today. I'd like to thank you for taking the time to come to Sudbury and listen to this submission. It's a fairly dense one. I'll try and get through it as comfortably as possible. I'm very pleased and thankful that the Honourable David Caplan and his staff have pulled together *Every Door Is the Right Door*, because it's a very interesting document and they have bravely put it forward into the public sphere for comment and feedback.

I'd like to thank anyone who's here simply for interest's sake and my employer, Noojmowin Teg Health Centre, for allowing me the time to come here and to prepare this report. Most of all, I'd like to thank my clients and co-workers over the past 12 years who have educated me to whatever extent I could take it in about the lived experiences of aboriginal peoples who are facing mental health and addiction challenges.

I think I present a relatively unique perspective as a provider of psychological services to rural aboriginal people. I'm a non-aboriginal psychologist and I've worked for my employer for 12 years, as I said. We service the First Nations communities and off-reserve people in the surrounding villages and towns on Manitoulin Island, and there's where I drove from today. So where you see Aundeck Omni Kaning, that is where our centre is located. The areas in red are the First Nations that we service, but as I said, we also service people who are living off-reserve, so they could be living in the towns or communities around the Manitoulin area, anywhere south of Espanola.

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I'm using the word "aboriginal" as it is used in the document *Every Door Is the Right Door*, but normally we would use the word "Anishnawbek" for the people of our area. The document is using the word as a catchword, really, for aboriginal, Metis and different designations, and that's exactly how we'll use it today.

I've chosen to focus on one issue within each titled section of the report. So my presentation is very report-focused.

Just by way of introduction, Noojmowin Teg is an aboriginal health access centre. These are funded by the provincial government with mandates to improve accessibility to health care services and to address challenges

related to family violence for First Nations aboriginal people. There are some of our relationships with our neighbouring communities and health authorities and some of the programs that we provide—a wide variety. You may be aware that the federal government funds a lot of aboriginal health programming, but we are filling in the gaps, and that's primarily in professional services such as nurse practitioners, dietitians and psychological services, as well as some specialized programming. We have exercise specialists and a fetal alcohol spectrum disorder program as well.

We were founded in 1997 and—the one that I want to mention that I forgot is the traditional medicine program coordinator. She oversees a program that coordinates traditional healing services and arranges for cultural teaching. It's a very fundamental aspect of our organization that certainly differentiates it from a community health centre that you might be familiar with in your own communities.

One thing that I'd like to mention is that Noojmowin Teg at its inception had the foresight to hire a psychologist, and that happened to be me. No other aboriginal health access centre actually hired a psychologist, so it was kind of a unique step in a certain direction. We have grown, largely because of the demand for services, to 2.2 FTE for psychological services.

We provide assessment and treatment services exclusively for aboriginal people across the Manitoulin area and, as I said, we also offer services off-reserve. We provide direct clinical services—that's our primary work—and we have serviced hundreds of aboriginal clients over the years, with a high rate of satisfaction, I may add. We had some of our services evaluated in 2007.

The Chair (Mr. Kevin Daniel Flynn): I think your slide show has developed a life of its own as you've been talking here.

Ms. Barbara Erskine: Yes, a life of its own, exactly. So when I need it, I guess—as I said, not my forte.

The first chapter of *Every Door Is the Right Door* is that mental and addictions touch lives, and I want to say how mental health and addictions touch aboriginal lives. In that chapter they speak a lot about the prevalence of mental health disorders in the general Ontario population. I just want to say something. You've probably heard a lot of news or headlines about the difficulties that aboriginal communities are beset with in terms of suicide rates and unintentional injury rates and other things that are related to mental health—substance abuse, of course, being one of the ones that gets a lot of press.

I want to just situate this in a context. Aboriginal peoples in Ontario have histories and legacies that are different from non-aboriginal people in Ontario. Just as an example, the original people of Manitoulin are from a group called Odawa. After contact with Europeans began, they could see that things were changing and they formed an alliance with a couple of other aboriginal peoples—Pottawatomi and Ojibwe. They also tried to form alliances with the government that was moving in—the white government and the British. They tried to forge

a nation-to-nation relationship with these non-aboriginal governors. In this effort, they did things like help the British out in the War of 1812 and sacrificed a lot of warriors in this cause.

In spite of their sacrifices, though, the settlers continued to move in. Sir Francis Bond Head, who was the Lieutenant Governor of Upper Canada from 1836 to 1838, tried to protect First Nations to a certain degree by saying that if the Ojibwe people signed over Manitoulin Island to the crown, that would be protected as Indian territory forever.

Less than 30 years later, as you can imagine, a new case was presented to the aboriginal people in 1862 because there was new land needed for settlers. The government applied pressure and renegotiated the agreement, possibly with the use of liquor in the bargaining process. So the land base for First Nations on Manitoulin Island was drastically reduced. This kind of history is just our local history that is repeated throughout the province.

There are other issues that came with that: the introduction of European diseases, legislation against culture and traditions, forced assimilation and residential schools—and on Manitoulin, many residents went to either Spanish River or Wikwemikong—and racism. So you may ask, "What does all this history have to do with mental health anyway?" I think that there's a lot of discussion now, especially, I would say, in native American psychological literature, about the phenomenon—perhaps the intergenerational phenomenon—of historical trauma. It would be likened to an anxiety disorder that bears some similarities to post-traumatic stress disorder. When we think about post-traumatic stress disorder, I think we pretty much have in mind some of the mental health challenges that are part and parcel of that, and the debilitation and impairment.

Fortunately, aboriginal people have survived these events and have preserved enough of their culture and language to sustain them—a spirituality, a holistic worldview, clan systems and other strengths that are allowing them to prosper to a certain degree, and certainly, their population is increasing. But I think anyone working with aboriginal people in a mental health or addictions social services setting needs to have some understanding of how the historical context may actually bear on the problems that you're seeing before you.

I would recommend that the government ensure that health care providers receive some education about the history and culture of aboriginal people somewhere in their curriculum as it may relate to health conditions and treatment.

The next section in the report is, "Can Services Do a Better Job of Meeting People's Needs?" They're talking about doorways into mental health services, and I want to talk about a doorway that wouldn't necessarily come to mind unless you were thinking about aboriginal health services. This is the doorway of traditional medicine and cultural practices. Within our agency and with some community partners, we have integrated our traditional medicine program and our mental health services such

that we take referrals from the traditional medicine program. Healers come in, they see people for the various either physical or mental health issues—they wouldn't call them that; they have other, more cultural ways of putting it—and they can see a need, that maybe this person needs to get into some treatment services. They will forward that name into our intake system, and we will take up that intake and coordinate our services with traditional medicine.

Similarly, we, as mental health practitioners, are asking all of our clients, "Do you have need of traditional medicine? Do you want some healing services? Do you want some cultural teachings? If you do, then we can direct you to them," and we make a referral back to the traditional medicine program. So we're trying to integrate our services the best that we can, and we are now starting some preliminary case management for clients who are using both types of services within our organizations. We are meeting and discussing them in kind of a case review and putting our best minds together and trying to think of, from both perspectives—the mainstream mental health perspective and the traditional practice perspective—what would be best for these clients. That's exciting for me, and I think that it would be good to acknowledge that traditional medicine programs for aboriginal people can be doorways to mental health services.

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I think the success of mental health programs in reaching aboriginal people is intertwined with the accessibility of traditional medicine programming. In our traditional medicine program, there is a set of policies and procedures that safeguards the clients who come in, much like any other health care policies and procedures do. I think that that also needs to be a bottom line for funding or implementing traditional medicine services, so I would recommend that the government fund traditional medicine programs in aboriginal health centres, maybe even at a level equal to the funding allotted for physical health programs and services.

The next chapter is "Transforming Services: Can We Make Every Door the Right Door?" This talks about diversity and culturally competent services.

I've brought up a definition of "culturally competent": "A process in which therapists develop an awareness of their own culture and clinical expertise, and subsequently enhance this information by allowing each client to express what is important for them about their culture as well as their treatment preferences."

Each service provider, aboriginal or non-aboriginal, I would say, needs to develop and have access to supports that will help them develop knowledge about aboriginal people.

One of the most daunting problems, though, I think, in providing mental health services for aboriginal people is that there is virtually no literature on what works. There is in fact an article that I've cited, by Joseph Gone, about his trying to survey the literature—he's a Native American psychologist—for studies of evidence-based

practices with Native Americans, and he comes up with nothing.

In other words, we're sometimes guessing at what works. What I would suggest, as a preliminary step, is to fund a conference to bring best minds together to start talking about this, and also to fund research in aboriginal mental health and addictions treatment so that we can have things like randomized controlled trials, clinical trials, for culturally adapted treatments, or even just develop treatments out of the practices within the aboriginal culture. But there is a lot that needs to be done.

The next chapter is "Act Early." As some of your previous presenters have said, there is absolutely no question about the importance of early identification and intervention.

We could briefly take a look here at the demographics of the aboriginal population. The median age is 24.7. That means that 50% of the aboriginal population is 24 years old or younger. When you look at the "Under 14 Years of Age"—I'll get that back—you can see that for the aboriginal population, that is 33% of the population, whereas for non-aboriginal it's 19%. When we talk about, "Do we need early intervention and early identification?", it is very urgent in this population.

It just mentions here too that on Manitoulin, we really have no children's mental health services coordinating committee. Largely, some mental health services are branches of services that are based in Sudbury or another urban centre, so that our issues are discussed but sometimes they're discussed in an urban setting. It isn't clear, maybe, sometimes, in an urban setting, how urgent it may seem in the field. When we're on Manitoulin Island, when you break down the population, almost 50% of the population is aboriginal: so, 5,000 non-aboriginal and about 5,000 aboriginal. Aboriginal people are our reality, whereas in an urban situation, they may be less than 10% of who is living in that area.

I would really like to see a children's services mapping exercise for just Manitoulin Island so that we could coordinate across aboriginal and non-aboriginal services and get a true picture of who is providing services and where the gaps are, and then to fund some sort of support at a lead agency on Manitoulin to coordinate a children's services planning table.

The next issue is how to meet people on their terms. In the document *Every Door Is the Right Door*, it talks about respect and value for diversity and going out and meeting the people who have mental health challenges. I think one of the best examples I can see of an organization going out and meeting people where they are would be the Northern Ontario School of Medicine, which has, as one of its requirements for its first-year students, to live, work and observe in First Nations communities for six weeks. That's kind of radical, I think. Congratulations to them for getting that done.

The Chair (Mr. Kevin Daniel Flynn): I'm going to jump in, just to give you some idea of where you're at. I think you've got 20 recommendations, you're at number 7 and you've got two minutes left. I don't want to hurry

you along, but you might want to focus on some of the things you absolutely want us to hear.

Ms. Barbara Erskine: All right. Anyway, the more time people can spend in aboriginal communities during their formative education years, especially in mental health and addictions, the better. If that could be facilitated, great.

The next item is the seamless and comprehensive provision of services across mental health and addictions. This is one point I really want to make, and it is that it is a fairly frustrating patchwork at this point in time of federal and provincial funding to serve aboriginal people, and making sense of it is very difficult at times. We do our best to collaborate together, but the funders sometimes are funding initiatives that go in different directions. They do not have integrated data collection systems, so we often have incompatible data systems. What I would recommend is that the LHIN and other LHINs that have a 10% or greater population of aboriginal people actually have a position where someone is trying to sort these things out, because it is above and beyond, as someone who is trying to do clinical work all the time. I think that would be a great step and very helpful for increasing understanding across all the borders.

Another point I wanted to make is about racism as an issue for mental health. It's just to say that the less racism people encounter, the lower the risk for some related mental health and physical health issues. I just cite some research about some possible impacts of racism on depression and other things like that. There's certainly more research than what I've cited, but I would encourage the government to sponsor any racism programs, to fund aboriginal culture centres to maintain and expand cultural recovery, and to fund institutions to have translation services.

I go on about education, the other thing, too.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much. This is really thorough and you've laid it out really well. Even though we weren't able to get to the end of it, I think all the members will spend some time with it. It's very easy to read; I read a little bit ahead as you were talking, and I think I get it. Thank you very much for coming out today and for all the work and the effort you've put into this.

I just ask, without promising or anything like that: Would your organization be open to a visit?

Ms. Barbara Erskine: Absolutely.

The Chair (Mr. Kevin Daniel Flynn): Okay. We have paid some visits to some First Nations communities, and that may or may not happen again. We're looking for some direct contact with people who would like us to come to their community.

Ms. Barbara Erskine: I could leave the name of our executive director with whom you could communicate about that. I'm sure that would be more than welcome; absolutely. Thank you so much.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Jeff, did you have a brief question?

Mr. Jeff Leal: Very brief. I looked at your 19 recommendations and I'll just give you my personal—I am parliamentary assistant for the Minister of Aboriginal Affairs. I happen to think that INAC is one of the great barriers in providing services. Through your experience, would you support the notion that the provinces, in particular the province of Ontario, should have 100% jurisdiction in delivering health services to our First Nations people? It's a controversial question, but—

Ms. Barbara Erskine: Oh, yes. That's why I want to turn the mike off.

In terms of organizing, there are so many political issues about land settlements, self-determination and these issues that need to be settled that are way beyond me.

Mr. Jeff Leal: But I specifically asked—

Ms. Barbara Erskine: About health care? Yes.

Mr. Jeff Leal: Because you've made 19 recommendations here and they all targeted on Ontario, which would have to provide 100% of the funding.

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Ms. Barbara Erskine: I know. I would—

Mr. Jeff Leal: So it's yes?

Ms. Barbara Erskine: Yes.

Mr. Jeff Leal: Thank you.

Ms. Barbara Erskine: To me, the province has the expertise in health care; that's their business.

Mr. Jeff Leal: I appreciate that.

The Chair (Mr. Kevin Daniel Flynn): Thanks for coming today, Barbara. We appreciate it.

COLETTE PILON

The Chair (Mr. Kevin Daniel Flynn): So if we can ask Colette Pilon to come forward and maybe start to get ready.

Everybody in Sudbury has laptops. This must be a cultural thing. Is it?

Interjection.

The Chair (Mr. Kevin Daniel Flynn): All set? You've got 20 minutes. You can use that any way you like, and maybe there'll be some time at the end for some questions.

Ms. Colette Pilon: Thank you. My name is Colette Pilon. I am a social worker. I have been involved in the planning and implementation phase of a transitional outpatient service to facilitate the transition of people who are admitted psychiatrically back into the community and give them that immediate support they need. I have about 10 years of experience working as a social worker in different functions in the system, and today I would like to speak more specifically in regard to my experience with the transitional outpatient service. I will conclude my presentation with some comments in regard to the broader context in which the current mental health system transformation is occurring.

I just need one second here.

The Chair (Mr. Kevin Daniel Flynn): These were supposed to make our lives easier.

Ms. Colette Pilon: It doesn't always work that way, let me tell you.

I would like to thank the select committee for providing me with this opportunity to share my experience and my perspective as a service provider.

In 2006, the need for a transitional community-based program had been recognized in order to facilitate the timely discharge of schedule 1 patients to community-based programs in order to alleviate the burden of bed shortages and the expected bed cuts that will be occurring again as a result of all services moving under the same roof. Ken White has recommended that funding be allocated to begin the process of developing the transitional community-based program.

We are about five people employed under the TOPS program, five clinicians of various disciplines. We underwent the preliminary research to guide the development for a service that truly responds to the needs of the community.

Our research has generated a wealth of information, and after a year in planning, TOPS was implemented in May 2008. TOPS is short—we're known as TOPS. Sometimes people confuse us with the weight-loss program. We like to say that TOPS is mental health weight loss, for the redirection.

In the planning process, we thought it was very important for us to align ourselves with the principles of the mental health direction. We looked at the documentation and we found a little bit of a formula that we used as the foundation of the program. We used the principle of the reform of the mental health system. Onto that, we added collaborative practice, and we ended up with a shared-service model of care; some of those highlights were described by the provincial ministry.

In alignment with the ministry's guiding principles, the Transitional Outpatient Service embraces the vision of a mental health system where:

- mental health and addiction services are fully integrated;

- primary care and mental health services work in collaboration to increase the capacity to meet clients' needs;

- access to services is seamless;

- services are coordinated to ensure the continuity of care of the patient upon discharge; and

- services are tailored to the needs of the clients.

Everybody talks about that, but what does that look like in real life when you try to design a program according to those criteria?

Collaborative practice: Collaborative mental health care describes models of practice in which consumers, their families and caregivers, together with health care providers from a variety of settings, will work together to provide better-coordinated service or more effective services for individuals with mental health needs.

Working in that direction, we have proposed the adoption of a shared-service model of care where service providers would work in collaboration to support

individuals transitioning from the in-patient setting to the community.

Central to the success of such a model is the ability to recognize that any specific intervention with a client needs to be seen as a part of a system of care. You need to be willing to consider other system adjustments or changes that need to be made to support the model.

Since its implementation in May 2008, TOPS has been a key player in facilitating the timely discharge of schedule 1 patients by providing immediate support to serve to people being discharged.

As the program expands, we are hoping to offer its support to individuals from the community as well. Initially, when we planned the program, it was designed to be some kind of a step up, step down. When people come out of the in-patient unit, they're stepping down from a higher level of service. The initial mandate was to design the program also toward the other way, to respond to the needs of the people in the community, should they be given that extra support in times of vulnerability with the immediate access as opposed to being put on a wait list. If we could provide that immediate access, we would be able to prevent many admissions and help people develop coping skills and deal with adversity in life. At this point, we have implemented only the former part where we are accepting referrals strictly from the in-patient unit because we simply do not have the resources at this point, the financial and human resources, to be able to accommodate the other component of the service, but eventually we're hoping to get there.

1150

One of the challenges is that, when we accommodate people coming from the in-patient unit, we're called upon to provide services to a group of patients that come out of the hospital and present with diverse diagnoses and also different levels of needs. That is definitely a challenge that we're facing regularly. Our admission criteria to the program are not diagnosis-specific, but rather, we base the admission criteria on the need for support after hospitalization. When most new services come up with their admission criteria, oftentimes the criteria are more exclusive as opposed to inclusive. But if we need to move patients from the in-patient unit to the community, we have to deal with that diversity of needs, and it is very challenging. If we say that we're going to respond to the people's needs, then we really need to adapt our service to those needs. That's why we keep our criteria flexible, providing that we do not compromise the safety of people participating in the group; we need to screen people carefully.

In terms of the diverse population, I kind of listed them there. I'm not going to go over that.

We have a crucial stakeholder in the planning of the services. We need to really work very closely with the in-patient unit. By working closely with the in-patient unit, we contribute to the seeding of a culture of shared treatment planning throughout the system; we need to start somewhere.

When we talk about shared treatment planning, this is basically one of the recommendations that the ministry

had put forth in its document *Making It Happen*. Shared treatment planning is actually necessary in order to be able to respond to people who have complex needs. What we have noticed is that when people are admitted to the hospital, they are a lot more ill than they used to be. There are lots of social and economic factors, all kinds of complex issues that people have to deal with, and when we need to provide for clients with complex needs, we need to have a coordinated approach to the discharge planning in order to ensure proper continuity of care.

When we work with the in-patient unit, we basically work towards the early identification of patients before they are discharged from the hospital. "Best practice" says that you meet the people on the in-patient unit; you present yourself; you introduce your program; and you invite them to come and participate in a couple of group sessions prior to discharge. We have noticed that when we do that, we have a much higher compliance with the referral or follow-through. We're seeking, actually, to establish contact with 95% of the clients before they are discharged. It's not always possible; sometimes we have a quick discharge and we don't have a chance to meet them. Then we'll follow up with a phone call.

I would like to provide you with a brief review of the successes and challenges that the program has registered so far. The program is currently accommodating an average of 90 active clients in the system at all times. Because of the need to accommodate a high volume of clients, the core service of the program consists of its recovery group, which is provided three times a week. As the name implies, the focus of the group is recovery. We need to keep in mind that "recovery" means different things for different people, and the quality of life and meaningfulness of life varies greatly from person to person. The culture of respect has been seeded and the clients have often commented about the safety of the group and the opportunity to interact with others and receive support from other people who understand.

In the first few months of the operation, we averaged between eight to 12 participants per group session. However, the number of participants has steadily increased. Lately, the average participants per group, after about a year of operation, is between 18 and 22 participants. We even have broken a record of 26 participants last week. So it kind of gives us an indication that maybe we are filling a gap in the system that had been expressed, and people are responding to that.

We try to gear the delivery of the program according to the comments that we have received from consumers when we conducted the initial needs assessment. The program is still developing. We are not quite embryonic, but not too far from there.

Challenges: Like I mentioned before, we have only achieved half of the mandate that we had initially set out to do, which is that we are offering the step-down level of service from the in-patient unit. We have put forth three recommendations: to hire one full-time position to dedicate to the screening of potential candidates, to ensure the continuous flow and smooth transition of pa-

tients; we're also asking to have additional resources deployed to further develop other groups and deliver groups, as well, in collaboration with other service providers. As it stands now, with the high volume of patient flow that we have—it keeps growing—we end up facing a challenge in terms of location, space and human resources to deliver the program.

The collaboration between service providers is something that has been talked about, and in your document I did elaborate a little more on that. But a crucial stakeholder is the acute in-patient unit, as I mentioned before. In order to effectively deliver the program, we go directly on the in-patient unit. We do participate in the case conference of patients where, every week, all patients in the unit are reviewed and they talk about the discharge plan and follow-up. We do participate in that so we have an idea of the population that we may receive in the program upon discharge, and we try to meet them in the in-patient unit before they come out. However, even though we are present on the in-patient unit, TOPS simply cannot assume the role of the discharge planning because we don't have, again, the human resources to coordinate the discharge planning of all patients. What we do is, when patients come to us, throughout the program, we do assess to see if there is any need for additional service providers to get involved.

The Chair (Mr. Kevin Daniel Flynn): Just so you know, Colette, you're down to about two minutes.

Ms. Colette Pilon: Two minutes. Okay. I think the documentation is pretty well explicit overall, at least I hope so. With constraints of time, I didn't have time to elaborate as much as I would have wanted to, but I would like to comment briefly on the fact that we have been speaking about mental health reform for many years and the need to integrate mental health and addictions services with the rest of the health care system. We have gathered lots and lots of information. Needs assessments have been conducted. We have the national survey, the Kirby report, which has yielded a whole bunch of information. They speak about gaps in the system, gaps at the policy level. They speak about the experience of the people. Services providers' voices were heard, and consumers' voices. We do have a whole bunch of information. In spite of a difficult economic reality, we're currently experiencing a positive political and social climate to guide the mental health and addictions strategy at the national and provincial level. The formation of the Canadian—

Interjection.

Ms. Colette Pilon: I'm out of time?

The Chair (Mr. Kevin Daniel Flynn): You're not exactly out, but you're getting out. You're near the end.

Ms. Colette Pilon: What I mean is that the ministries at the federal and the provincial levels do recognize that there is a need for a mental health and addictions strategy, and there is also a big receptivity in what we have noticed on the in-patient unit. There are lots and lots of dedicated staff in the community as well. Everybody seems to be—if not everybody, many workers seem to be

really engaged in improving the system. I think that it's the prime time to act now with the information that we have.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Colette. That was a great presentation. Thank you very much for coming today, and thanks for the work you put into it.

Ms. Colette Pilon: You're welcome. Thanks for having me.

CANADIAN MENTAL HEALTH ASSOCIATION, NIPISSING REGIONAL BRANCH

The Chair (Mr. Kevin Daniel Flynn): Our last presentation before lunch is a phone conference with the Canadian Mental Health Association over in Nipissing; Georges Kristolaitis. We're just getting him on the phone as we speak.

The committee recessed from 1203 to 1206.

The Chair (Mr. Kevin Daniel Flynn): All set? George, are you there? Hello? George, are you there?

Mr. Georges Kristolaitis: Yes. Are we back on?

The Chair (Mr. Kevin Daniel Flynn): You're back on again. It's Kevin Flynn, the Chair of the committee, speaking right now.

Mr. Georges Kristolaitis: Excellent.

The Chair (Mr. Kevin Daniel Flynn): The entire committee is with us this morning. You've got a couple of people in the audience here in Sudbury.

We've been giving everybody 20 minutes. We've been keeping on schedule to a certain point, I think; we're not too far off schedule. You've got about 20 minutes, and you can use that any way you want. If you could leave some time at the end, maybe, for some questions, that's great, but it's not necessary.

Mr. Georges Kristolaitis: Absolutely.

The Chair (Mr. Kevin Daniel Flynn): Okay, it's all yours. Thanks for joining us today.

Mr. Georges Kristolaitis: Thank you for adding CMHA Nipissing to your list of deputants. I know you have a very busy schedule and it's probably lunchtime now, so we thank you for your extra work and duty on this. What you're doing is a very important task of going out to meet the field.

I'm Georges Kristolaitis. I'm the executive director with CMHA Nipissing. With me is Rhea Funnell, who is the program manager with our Bridges housing and Bridges Voluntary Trusteeship service.

Our presentation will be brief: about 10 minutes. I'll be sending a written summary of our speaking points to the clerk of the committee.

By way of background, CMHA Nipissing is a community mental health service provider. We operate in the district of Nipissing. We serve adults who are living with mental health disabilities. Our budget is just over \$2.2 million. We have a staff of about 35. We serve just over 550 clients.

CMHA has been operating since the late 1980s. We've grown organically during the last 30 years, such

that right now, CMHA provides a wide array of services related to housing, case management, social rehabilitation, mental health promotion, mental health justice services and referral assistance.

We operate in partnership with all of our local mental health agencies. Very importantly, we're constituent members of two key groups: the Nipissing common referral form protocol, which helps people access support services in the district in a coordinated fashion, and the Nipissing housing selection committee, which facilitates placement in supportive housing programs.

We basically have one key message to the select committee: We want to describe for you a current innovation in service delivery in our district that we're very much a part of. CMHA, along with a couple of other agencies, has a shared-service delivery model, and one of our programs, CMHA's Bridges voluntary trusteeship service, illustrates that model very well. Our strong recommendation is that every community would benefit from adopting a shared-service model and also that they should have, in our view, a voluntary trusteeship service as an essential component of that model.

I will ask Rhea Funnell to present to you elements of the shared-service model and how the voluntary trusteeship service illustrates that.

Ms. Rheanon Funnell: Good afternoon. Again, my name is Rhea Funnell. I'd like to thank you for this opportunity.

As George has already stated, the services offered by our agency have evolved from the identified needs of our community and the people we serve. Because North Bay has a schedule 1 facility within the municipality's geographic boundaries, the percentage of individuals living with serious mental illness within this district has always been slightly higher than the provincial average. The sheer size of the hospital's catchment area and the remoteness of the geography and the population centres have meant that the service provision has to be given in as innovative, collaborative and resource-saving a manner as possible.

The shared-service model found at CMHA Nipissing is used in all levels of service, including access, assessment and service delivery. Shared services are designed to provide holistic supports that are planned around an individual's needs. Supports are not duplicated, but enhanced. The Bridges voluntary trusteeship service exemplifies this model. Bridges currently serves almost 100 adults living with serious mental illness in the district of Nipissing, and the wait list stands at almost 80. Of the 100 current clients, almost 80 are shared-service clients with other formal supports in place.

The service works collaboratively with other supports to create a service plan with the person being served that is self-directed and inclusive. The service also allows primary supports to concentrate on the therapeutic relationship, while the removal of financial worries also helps alleviate stress.

Currently, the common referral and triage process provides streamlined and coordinated access to long-term

community supports, including the Bridges voluntary trusteeship. There are five agencies that actually belong to that process. The Ontario common assessment of need, or OCAN, will enhance the communication between services by providing a shared language.

Wait lists remain a major obstacle for individuals seeking service. The shared-service model allows agencies to stretch resources in a coordinated and integrated manner to serve more of the population in need.

We have also chosen to create a shared-service model for our housing. Nipissing was one of the first districts in the province to approach housing of individuals who are living with a serious mental illness from a systemic level where the supports actually access the housing through a committee, a selection process. We believe that the shared-service model will help to stretch resources in a way that will, in the end, lead to better service overall.

Mr. Georges Kristolaitis: That's the end of our prepared presentation. We're quite open to any questions or comments the select committee may have.

The Chair (Mr. Kevin Daniel Flynn): George, thank you very much. Thank you, Rhea. Let's start with France.

M^{me} France Gélinas: Good afternoon, and thank you for your presentation. There are themes that have been coming up that I wanted to run by you to see if they hold true for your agency.

A lot of people have presented to us about the need to formally recognize and fund peer support. I was wondering if this is something that you use and if you have been creative in finding ways to fund peer support.

Mr. Georges Kristolaitis: There are strong peer support organizations operating in Nipissing and they're a very important ingredient to the whole complexion of services and active groups in the community.

Some of our programs may have clients who provide leadership. They are peers or are people who have gone through, I suppose, the psychiatric disability and recovery experience. They are very much needed. One of our first programs, the Centre of Friends, which is a social rehab recreation service, has a pal program. What that does is it extends service, activity, conversation etc. in that centre.

Ms. Rheanon Funnell: The use of peers certainly does enhance the service provision. The formalized creation of peer support positions has been something that has been happening on a regular basis in the Nipissing district. Our ACT team has peer support workers. We do have consumer-run organizations here as well. I think what we've discovered is that, again, that is another piece of service provision that has evolved naturally as much as anything else.

We also provide coordination of something called the TAMI program, which is Talking about Mental Illness. That has been a very intrinsic part of our education and mental health promotion service where individuals who are consumers of mental health services go out into the community, into schools and businesses, and talk about their experience in the mental health system and help educate people and also alleviate some of the stigma.

Mr. Georges Kristolaitis: And these presenters are the stars. Wherever presentations occur, they want to hear the real-life experience, they want to meet individuals who have recovered from serious mental illness, and we recognize that very strongly. The TAMI program is one of the projects that we are involved with with other agencies as well.

The Chair (Mr. Kevin Daniel Flynn): Thank you George. Let's move on to Liz Sandals.

Mrs. Liz Sandals: Thank you very much for your presentation. You mentioned the Bridges voluntary trusteeship service. I wonder if you could explain what that is.

Ms. Rheanon Funnell: Back in the 1980s, when CMHA Nipissing first began, it started as a social rec program, primarily because the schedule 1 facility, which was then called the Ontario Hospital, was discharging individuals into the community and there weren't any real supports for them and certainly no social supports. So the social rec program started from that, and then as time passed, people recognized that there was a need for individuals to have help with finding housing, because there was no way for them to find housing. So the original Bridges service started that way, and within a short space of time evolved from that because what was happening was, people would find housing and then they wouldn't be able to keep their housing because they wouldn't have any help with their finances. So the voluntary trusteeship service actually started in the late 1980s from that recognized need within the community.

Since then, it has evolved on its own to become, really, a clinically based psychiatric service for individuals living with serious mental illness within this community. The workers work with people to develop a monthly budget and they also help them recognize the connection between the stressors of their finances and their mental health. They also work in collaboration and case conferencing mode with the other supports that the person has, the formal supports that they have.

We have, as I said, almost 100 people currently on our roster. It is a voluntary program, so the individuals we're serving are people who have chosen to come to us and to work with us on their financial issues. The goal is to move people off so that they become totally financially independent and can actually work for themselves and move forward that way so that we can take other people off our wait list.

Mrs. Liz Sandals: So are the people who are involved in that program voluntarily signing over financial trusteeship to your service?

Ms. Rheanon Funnell: That's correct.

Mrs. Liz Sandals: But it's strictly a financial arrangement; it's not got anything to do with medical decision-making?

Ms. Rheanon Funnell: No, it's just finances and it's totally voluntary. People can leave it at any time. We have arrangements not just with the people we serve but also with the Ontario disability support program and other financial supports. It's a fully audited service, so

we're very careful to make sure that everybody knows exactly how much money is theirs and where it is on a monthly basis. The budgets are designed around what the individual wants and needs. They change on a regular basis, depending on how they want it to proceed.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Rhea.

Mr. Georges Kristolaitis: I would add the comment that I think on an annual basis there are 10,000 cheques that are cut for our 100 clients in the program. It's amazing how supporting it is to know that your rent's paid, your utilities are covered and you have a plan for your food and clothing needs.

The other thing we find is that when people are starting to have difficulty with their mental health, it shows up in how they spend their dollars. How we help them spend their dollars according to their plan supports recovery. So the program has four field staff, a part-time manager and a full-time administration clerk who keeps track of all the cheques, the invoices, etc. People have the choice of coming in once a month for that one cheque that they might need or two times a week or three times a week—whatever they need to sustain their financial life and also their tenure in the community.

The Chair (Mr. Kevin Daniel Flynn): Thank you, George. We've got one final question: either Christine or Sylvia.

Mrs. Christine Elliott: I just have one quick follow-up question, if I might, on the same subject. I can understand that normally this would be a function that the public guardian and trustee would fulfill, but there are some personal service elements to this that I can appreciate, being in this area, make it preferable to the public guardian and trustee handling that. I'm just assuming that you've got some kind of a relationship with them and that they are on board with this.

Ms. Rheanon Funnell: We actually do have individuals who are with OPGT. Occasionally we do take on people who are with OPGT at the same time as they're with our service. However, the prerequisite for us is that the individuals we serve need to be able to come off the service eventually.

The individuals we are serving are people who are perfectly capable of making decisions about their finances and about other things in their lives. They are living totally independently and capable of doing all of those things, but they have asked us to help them. That's where the voluntary aspect of this comes in.

The other big difference, of course, between us and OPGT is the fact that if people want off, they just say, "I want off." There's no hold to them about their finances or anything else. It's totally their dollars, and we help them handle them.

Mrs. Christine Elliott: So it's really a capacity/incapacity kind of test that you apply, then, because these are people who are otherwise fully capable of managing their own finances.

Ms. Rheanon Funnell: Absolutely. We don't even apply a test. The criteria for accessing the service has to

do with whether or not the person has a serious mental illness.

Mrs. Christine Elliott: Thank you.

The Chair (Mr. Kevin Daniel Flynn): George and Rhea, thank you very much for joining us today. That was great input.

Mr. Georges Kristolaitis: Thank you very much for this opportunity.

The Chair (Mr. Kevin Daniel Flynn): Our pleasure; any time.

Ms. Rheanon Funnell: Hopefully you'll enjoy your lunch.

The Chair (Mr. Kevin Daniel Flynn): I know; we can't wait.

Mr. Georges Kristolaitis: Okay. Good day.

The Chair (Mr. Kevin Daniel Flynn): Nice meeting you both. Goodbye.

We're adjourned for lunch now. We've managed to ask the conference call that was scheduled for 1 o'clock to move to a different time, so we actually have time to enjoy our lunch a little bit. We'll have about an hour for lunch. So we're back at 1:20. Okay? We're adjourned.

The committee recessed from 1223 to 1323.

SOCIÉTÉ ALZHEIMER SOCIETY SUDBURY-MANITOULIN

The Chair (Mr. Kevin Daniel Flynn): Okay, if I can ask you to come forward. You must be our next delegation. Are you?

Interjection: We thought that was a teleconference.

The Chair (Mr. Kevin Daniel Flynn): No, actually, that's been changed. So if you're Patricia or Debbie, you'd be up next.

Interjection.

The Chair (Mr. Kevin Daniel Flynn): No. You pick whichever one you're more comfortable at. There should still be clean glasses there if you need some water. You guys can get settled. Everyone has been getting 20 minutes for their presentation, and you can use that any way you see fit. If you want to leave a little bit of time near the end, if that's possible, for questions and answers, that seems to work out nicely as well. So if you want to get nice and settled—

Ms. Patricia Montpetit: Is it the one with red flashing—

The Chair (Mr. Kevin Daniel Flynn): They'll turn it on for you.

Ms. Patricia Montpetit: This will be the one that works?

The Chair (Mr. Kevin Daniel Flynn): Yes. All you have to do is have a thought.

Ms. Patricia Montpetit: A thought?

The Chair (Mr. Kevin Daniel Flynn): I don't know how it works.

Okay. We've got everybody in the room, so let's get going. It's all yours.

Ms. Patricia Montpetit: Okay. Thank you very much. Mr. Chairman, members of the select committee,

ladies and gentlemen of the audience, thank you for this opportunity to address your committee. I'm here today on behalf of the Société Alzheimer Society Sudbury-Manitoulin. With me is my colleague Debbie Szymanski. Debbie is the manager of the utilization department at the Laurentian site of the Hôpital régional de Sudbury Regional Hospital.

The Société Alzheimer Society Sudbury-Manitoulin is a non-profit charitable organization that has been operating for 24 years. We are one of 39 local chapters of the Alzheimer Society of Ontario. We provide services to support people with Alzheimer's disease and other degenerative cortical dementias such as Lewy body disease, vascular dementia, Creutzfeldt-Jakob disease, Pick's disease and Korsakoff's syndrome. Our chapter provides support groups, First Link, family counselling, education sessions, an adult day program, in-home respite services, a resource library and staff training for agencies that also serve clients with dementia.

We are currently providing services to over 550 families throughout the districts of Sudbury and Manitoulin. Demographic data projections estimate that there are currently 2,700 persons with dementia in our two districts. These numbers are expected to rise to 4,650 over the next 20 years.

The Alzheimer Society has a partnership with the Sudbury Regional Hospital and several other community agencies to address the needs of a particularly vulnerable part of this client population. Debbie and I are here today to highlight for you the growing need for specialized care for patients in the later stages of dementia who demonstrate complex and difficult behaviours.

Why is this a problem? These behaviours affect their ability to live and function in both the community and present health care facilities. Some of these patients have had mental health problems in their past life, and these are now compounded by their dementia.

Did you already hear a presentation from my colleague in North Bay, Linda Brown? She was going to be talking to you via teleconference.

The Chair (Mr. Kevin Daniel Flynn): No. She's the person we were supposed hear from at 1, but we were late for lunch, so we put her off to 2:20.

Ms. Patricia Montpetit: Oh, I see.

The Chair (Mr. Kevin Daniel Flynn): But we are hearing from her, for sure.

Ms. Patricia Montpetit: I believe she will be talking in her presentation about stigma and dementia. It's important to understand that dementia is a highly stigmatized condition.

In 2006, a nationwide public opinion poll revealed that Alzheimer's disease is the second most feared disease by Canadians, preceded only by cancer. This fear is rooted in the misconceptions and stigma surrounding dementia. One of the greatest misconceptions about dementia is that the condition causes people to become aggressive or violent. In fact, only a small percentage of people with dementia exhibit these behaviours.

In the past, these behaviours were referred to as aggressive or volatile behaviours. We prefer to call them responsive behaviours, as they actually are the person with dementia's response to a trigger in their environment that they perceive to be threatening. These behaviours can and do cause harm to the persons themselves or to others around them, including other patients, and also caregivers.

As a result of their unique challenges, these clients often cannot be cared for in the community. They frequently end up living in an acute care hospital setting with no discharge designation. In fact, during the past year, Sudbury Regional Hospital has averaged seven to eight alternative-level-of-care patients per day who have responsive behaviours resulting from dementia.

The long-term-care homes and other facilities often cannot accept these patients for admission into their facilities as they feel they are unable to meet their specialized needs. They are concerned for the safety of their other residents and their staff. These patients therefore become homeless, and as a result they end up living in an acute care hospital setting. This has created a huge bed management challenge. At the Sudbury Regional Hospital, this patient population accounted for approximately 2,555 patient days in acute care beds in the past year, and this scenario is being repeated in hospitals throughout the province.

1330

Quality of life becomes a huge issue for these patients. Persons with dementia need to be supported in caring and dignified environments, with opportunities for meaningful and therapeutic activity consistent with their individual strengths and potentials. Hospital wards are not designed for, or resourced appropriately, to provide the care that they need. As a result, behaviours often escalate in these settings, and sometimes chemical restraints are the only alternatives available to defuse difficult situations.

Sixty-five per cent of the residents who currently live in long-term-care homes in Ontario have some form of cognitive impairment. As their diseases progress, some of these residents also develop responsive behaviours, and the homes have difficulty managing their care appropriately and safely. This can result in emergency room admissions or transfers to hospital, and in other instances it has led to resident injury and even death. One such tragedy occurred at a nursing home in Sudbury two years ago when a resident killed his roommate. The Casa Verde home in Toronto experienced an unfortunate violent resident death in 2001, which led to a provincial inquest. One of the 85 recommendations of that inquest was to implement specialized units to meet the needs of individuals with assessed mental health and behavioural challenges. I have to say that we are disappointed in the progress that has been made to date since that inquest made those recommendations.

So what is the solution? The province needs to put in place additional specialized geriatric mental health services which provide added expertise in diagnosis,

behavioural strategies and pharmacological treatment. Key resource requirements include the following. First, staff throughout the continuum of care need specific training on how to prevent people with dementia from developing responsive behaviours and how to care for those who do. There are several training modules that have been developed specific to working with this population. One is called PIECES, another is U-First, and the gentle persuasive approach is another. However, there is insufficient funding in the system to provide this training to all those who need it.

Second, integrated support teams need to be available in each community which would take a case management approach to support the individual's needs regardless of where the client is residing.

Third, specialized responsive behavioural assessment units need to be established in every region across the province. These units need to have specially designed environments, security and trained staff. They need to have sufficient resources to provide a safe environment for both residents and staff. These behavioural assessment units would provide assessments and treatment plans for individuals who are presenting challenges in their current settings. Then they would be transitioned back to their referring facilities, allowing the unit to be able to serve additional people. There are only a few examples of behavioural assessment units currently operating in Ontario. These include the Dorothy Macham Home at the Sunnybrook Hospital and the T. Roy Adams Regional Centre in St. Catharines.

The North East Local Health Integration Network is very aware of the need for these resources. In 2007, ALC task forces across the North East LHIN identified the need for this range of services, and this past year, Sudbury's ALC steering group identified specialized services for this population as one of its 10 priorities.

Here in the Sudbury area, several agencies and facilities have been working together to determine what our community needs to address this population. This cognitive working group was spearheaded by the Sudbury Regional Hospital, and we're developing a proposal for both an integrated community support team and a behavioural assessment unit. We hope to receive funding from the North East LHIN to address this gap in our continuum of care.

What can you do about this? Besides the need for additional resources, some provincial policy barriers currently exist that make integration of the support system difficult. For example, some of the rules around discharge, time away and readmissions to long-term-care homes need to be revised to allow enough time for behavioural assessments to be effectively completed, and there is some policy work required on wait-list management for specialized units.

In conclusion, we would urge the select committee to include in your report a specific recommendation to government to establish a system of supports for persons with responsive behaviours.

Thank you very much for your attention to the needs of this vulnerable group of Ontarians.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much, Patricia. You've left some time for questions, about two minutes for each side. Let's start with France.

M^{me} France Gélinas: Thank you, Pat. I was interested in the "key resource requirements include"—the first one was about training; the second one, integrated support teams. Can you talk to me a little bit more about how this would work?

Ms. Debbie Szymanski: I guess one of the biggest challenges we see is, you don't just want to build a unit; you want to build it so that it can continue the flow. We need some expertise, which we have a little bit of—there are very limited resources in the northeast, specifically—where the teams would come to the patients and clients to avoid moving them. It's the same as the aging-at-home strategy. It's the same idea.

If you're in a long-term-care facility, we don't want to be uprooting you. A lot of that work has occurred with our limited resources already. What we're suggesting is that there's actually a specialized team, some resources put to that so they don't end up going to emergency. You have people coming in with the expertise to support them in a group home, in a long-term-care facility, to do the assessment, do the medication readjustment and then escalate them to the specialty-care unit if required.

I think one of the biggest challenges with the units they presently have in the province is that you just don't move them there, and of course you're going to end up with a huge wait-list and you'll never have enough resources. I think it's the same as the challenges with the long-term-care homes.

Having the integrated team is a key part, not just building the unit. You want to keep as many of the clients and patients as you can where they are, safely. I think that that's the key part that we're lacking.

M^{me} France Gélinas: As well as, we don't have the unit.

Ms. Debbie Szymanski: We don't have the unit. That's right.

M^{me} France Gélinas: The second is, at the very end, when you said there are some policies that need to be revised, I'm thinking that you're talking about the 21 days if you're gone—21 days from your bed, then the bed is given up.

Ms. Debbie Szymanski: Yes.

M^{me} France Gélinas: How long do those specialty-care units need to work for—and how do you see this working?

Ms. Debbie Szymanski: I think there are two points with it. The wait-list management that's managed through CCAC deems that, unless there's a specialty unit—for example, right now on the wait-list, if you apply for a placement but you have specialty needs, you're put into the big bundle and pot. So if a specialty bed comes up and, say, we had our unit right now in Sudbury somewhere, that particular patient would not go on a specialty responsive behaviour list. So if the bed came up in that unit, CCAC could not offer it to the appropriate patient. There needs to be that policy change

on how specialty units, the specialty process, has to be defined.

On the second part of the 21 days, I'd hate to see empty beds in the system, as there isn't enough, but we would like to guarantee that the patient would get back to the same facility. We're not really saying as a policy that you'd want to hold the bed, because right now, with the mental health—they could stay 45 days. Understanding that, in our hospital right now, we have about 85 to 90 placements waiting for that particular bed, it would be statistically kind of—a lot of empty-bed days in the province. But I do believe there's some opportunity to allow those clients to have a priority to get back to their facility. That's home.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Debbie. Anybody from this side? No? You're good? Christine or Sylvia?

Mrs. Christine Elliott: A quick question: You mentioned earlier the Casa Verde inquests and that you were disappointed at the lack of uptake, I guess, on some of the recommendations with respect to the specialized units. Do you have any idea how many of them have been created?

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Ms. Patricia Montpetit: How many specialized behavioural assessment units?

Mrs. Christine Elliott: Yes.

Ms. Patricia Montpetit: We're only really aware of the two that we mentioned. There are a number of projects around the province that are trying to get funding to get started but they have not yet succeeded, I guess, because there is no pot of money for this. You have to kind of—

Ms. Debbie Szymanski: Create. And I think that for here we've done as much from subgroups and working groups. We've done the integration, the education, the communication, but now we actually need the mortar and the bricks—

Ms. Patricia Montpetit: The money.

Ms. Debbie Szymanski: —and it's not there structurally, because it's a unique and growing need. Many of these patients we highlighted have had a mental health diagnosis in the past, which actually compounds the care of them because: Is it the dementia? Is it their past mental health challenges or diagnosis? Often you need a team of a psychiatrist, family physician and gerontologist, so you have three or four pods. I think statistically we did a study here regionally: At least 30% to 40% of those with the dementia also have a mental health diagnosis. So that's why we're here. It's not in isolation. And if you know that one out of every three people have some type of mental health challenge throughout their life, statistically that makes sense. Once you've been labelled with that, that stigma comes back and it becomes very difficult to find a home, as you're probably hearing from other speakers. So it's a very complex patient and a challenging situation.

Mrs. Christine Elliott: Just one quick follow-up: Do you need to have a different kind of specialized team to

work with this group of people, as opposed to some of the other integrated teams we hear about that work in other areas of mental health and addictions, for example?

Ms. Patricia Montpetit: Yes, because this is a geriatric population. For example, the ACT teams that are in the community wouldn't touch this group.

M^{me} France Gélinas: Do we have a second left?

The Chair (Mr. Kevin Daniel Flynn): Yes, we do.

M^{me} France Gélinas: Can I have it?

The Chair (Mr. Kevin Daniel Flynn): That was it.

M^{me} France Gélinas: Is there an appetite out there within the nursing home operators to have those special responsive behavioural assessment units or are they a tough sell?

Ms. Patricia Montpetit: Well, the opportunity for them to get such a unit hasn't come up. I think we could probably find a long-term-care facility that would be willing to implement this if we were able to come up with the funding. It would probably require either a retrofit or choose one that's about to be built, for example, and ask them to take this on as a specialized need.

M^{me} France Gélinas: But the funding would be over and above what they get for the daily—

Ms. Patricia Montpetit: Definitely. They could never do it with the per diem rates that they have for long-term-care facilities.

Ms. Debbie Szymanski: We researched that in coming up with a proposal that I'm just finishing up, and one of the things they're saying is that at minimum, with the ones that are functioning, you'd need an additional \$100 to \$150 a day on an operational basis, so yes—

Ms. Patricia Montpetit: Per patient.

Ms. Debbie Szymanski: Per patient. Really, because if you look at their specialty needs, often needed is one-on-one for the first assessment period, a totally different type of challenge, and the challenge out there is that there are not a lot of data because there are not a lot of units to establish the cost per patient day that's required.

M^{me} France Gélinas: The two that are there, who pays for those?

Ms. Patricia Montpetit: The Ministry of Health.

M^{me} France Gélinas: Do they? Okay.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today. Thank you for your presentation.

TERRIE PITFIELD

The Chair (Mr. Kevin Daniel Flynn): Our next presenter today is getting set up, and it's Terrie Pitfield.

Hi, Terrie. Thanks for joining us today. Everybody has been given 20 minutes today, and you're exactly the same. You can use that any way you see fit. If you'd like to leave some time at the end for discussion, that's entirely up to you. It's not necessary, but it usually works best.

Ms. Terrie Pitfield: Okay, perfect. Thank you for having me.

I do a lot of presentations, and I have to say, this is one that makes me—I put it a lot of thought into this presentation. It's about my personal struggles with mental health and addiction issues. It is by far the most important presentation, I have to say, that I've probably given. Changes need to be made to a mental health and addiction strategy, so I'm so grateful that you're all here and you're having these meetings across the province. So I'll get started.

I titled this *Bringing Mental Health and Addiction Treatment into the 21st Century: Strategies Based on Science as Opposed to Ideologies*. I have two quotes in this presentation. Both are from Dr. Gabor Maté's book *In the Realm of Hungry Ghosts*. I'm sure some have read it. It is an amazing book, and I think anybody who is in the field of mental health and addictions should read it. He's right on.

"So what is addiction, really? It is a sign, a signal, a symptom of distress. It is a language that tells us about a plight that must be understood."

Who I am: I'm an aboriginal two-spirit woman. For those don't know the term "two-spirit," I identify as lesbian. In aboriginal teachings, two-spirited people were very much revered and honoured. Since the arrival of Europeans and colonization, homophobia is very much, unfortunately, ingrained in aboriginal communities. It is not an original aboriginal value. I'd just like to say that.

I struggle with mental health issues which have resulted in a predisposition to alcohol and drug use. I was adopted at three months into a wonderful, loving adoptive family. Despite that, I began using alcohol at 14. I got sober at 29. When I was 17 years old I had a major identity crisis. I realized I was lesbian at that time and had been adopted—this was hidden from me. I felt completely lost, disconnected and alone. My parents just never felt it was the right time to tell me I had been adopted, so I had a major, major identity crisis at that time, as you can imagine.

A key factor, I believe, was the adoption. Also, my birth mother was 45 years old, possibly drug-addicted, definitely homeless. She was a sex trade worker, incarcerated while she was pregnant with me, and had a history of mental illness. I'm not sure what exactly. My siblings insist that she was schizophrenic at the time, but I saw her at the end of her life and I don't believe she was schizophrenic. She was never clinically diagnosed. She also had a history of extremely abusive relationships with men.

According to Dr. Maté's book *In the Realm of Hungry Ghosts*, "Numerous studies in both animals and human beings have found that maternal stress or anxiety during pregnancy can lead to a broad range of problems in the offspring, from infantile colic to later learning difficulties and the establishment of behavioural and emotional patterns that increase a person's predilection for addiction. Stress on the mother would result in higher levels of cortisol reaching the baby and, as already mentioned, chronically elevated cortisol is harmful to important brain structures especially during periods of rapid brain development."

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He goes on: "Any woman who has to give up her baby for adoption is, by definition, a stressed woman. She is stressed not just because she knows she'll be separated from her baby, but primarily because if she wasn't stressed in the first place, she would never have had to consider giving up her child: The pregnancy was unwanted or the mother was poor, single or in a bad relationship, or she was an immature teenager who conceived involuntarily or was a drug user or was raped or confronted by some other adversity. Any of these situations would be enough to impose tremendous stress on any person, and so for many months the developing fetus would be exposed to high cortisol levels through the placenta. A proclivity for addiction is one possible consequence."

This is what I believe: There is a definitive link between mother-to-child cortisol levels that have set the stage for my mental health and addiction struggles.

Also, the primal wound that is created when an infant is removed from their biological mother creates additional issues that need to be widely researched and addressed as they relate to mental health and addiction.

If future adoptive parents are made aware of the scientific evidence and the potential for addictive behaviours and/or mental health challenges, they can be given the tools to aid their child's development. These tools may include proper diagnosis by a mental health professional, medication, exercise, and techniques such as meditation and introduction to spiritual outlets, such as native teachings and Buddhism.

If I had been properly diagnosed at a young age, given proper medication and alternative outlets to deal with anxiety—why I felt the need to use drugs and alcohol to cope with life—it might have saved years of struggle for me.

Moving along in my journey: I was sober for 12 years. I attended AA meetings. I still struggled with some mental health anxiety issues, and I was told it was because I wasn't really "working a program."

Ten years into my sobriety, I started self-medicating with Tylenol 1s, occasionally OxyContin and Ativan, to deal with stresses in my life. Not surprisingly, I picked up a drink in December 2008, drank twice after that and, in order to deal with the shame and guilt around that episode, continued to self-medicate with Tylenol 1s, T3s if I could get my hands on them—they're not hard to find—and Ativans.

I thought I was intrinsically flawed. That's what Alcoholics Anonymous told me. I was unable to deal with life on life's terms, incapable of being honest with myself and others.

After pleading with my doctor, being honest about my drug use and self-medicating and drug seeking, he prescribed trazodone 50 milligrams in addition to the 300 milligrams of Effexor that I'd been taking for about eight years.

Since I've started that medication, things are much better. I no longer need to go and buy Tylenol 1s over the

counter to deal with my anxiety and everyday stresses that someone who is not suffering from a mental health issue would have no problem dealing with.

He also made a referral to a psychiatrist, and I am still waiting for an appointment.

If I had not insisted, with him, "If you do not prescribe something for me, I will continue to find the drugs that I need to deal with my stresses"—at that point, I think he got it, and he agreed. So I'm very grateful.

I feel stable today, able to focus, concentrate and do those things that aid in my recovery and allow me to be a contributing member of the community.

What I know for sure: My mental health and addiction treatment requires a combination of therapies, not all in this order: medication, exercise. Meditation has been a wonderful outlet. Meditation is really, really important for people who are dealing with mental health and addiction issues.

AA meetings: I still go to meetings. I still "work a program"; I guess now I'm really working the program. Counselling: I see a counsellor once a month, and I have a really, really good spiritual connection which I have developed and found a lot of help with through Buddhism principles and teachings, native teachings and, of course, the 12-step program.

My hopes:

—a mental health and addiction strategy that would encompass extensive research into the links between trauma, stress and the biology of addiction;

—culturally based mental health addiction services specific to the aboriginal population and their unique issues: This would include education around the history and impact of colonization, residential school trauma, adoption and foster care issues, loss of culture and generational trauma. As a people, many believe we are intrinsically flawed when there are legitimate reasons why we are collectively so unhealthy as a people;

—multi-faceted approaches which would include all possible treatment options—spiritual, physical, emotional and mental;

—a widespread campaign to address stigma and discrimination;

—education and training around harm reduction as a legitimate and effective strategy in dealing with mental health and addiction issues;

—implementation of harm reduction as one of the core principles of a mental health and addiction strategy for Ontario;

—a spiritual component that provides easy access to all spiritual options. That may include access to spiritual retreats, spiritual teachers and the healing powers of mindfulness meditation; and

—training for mental health and addiction professionals around the benefits and legitimacy of medication as a combination therapy instead of just another attempt by drug users to obtain drugs.

Finally, something that is really, really important for people is a loving non-judgmental connection with other human beings. That can be done through spiritual teach-

ers, an elder, 12-step sponsors, a peer or people who volunteer and want to spend time with individuals who are on a healing journey.

As for my birth mother, I did meet her two years ago. She was 85 then. She had suffered a stroke eight years before that and was living with my birth sister. She did not acknowledge that I was one of her children, which was okay with me. I was one of two that she had relinquished at birth. For the very limited time that I spent with her, she never talked about the past, except to say that her childhood was wonderful. Unable to have any loving relationships throughout her life, including with her seven children, she lived much of it in poverty and isolation. She passed away at 87 in May of this year. I sat at her bedside the evening before she passed, and she gave me a smile. That was good enough for me; she acknowledged that I was there with her.

So full circle: It is not surprising to me that I do the work that I do, involved in street outreach on the same street where my birth mother worked and lived in the late 1960s here in Sudbury on Elgin Street. I also do programming in the Sudbury jail with high-risk aboriginal men and women around safer sex practices, harm reduction techniques around their drug use and the services that are available to them in the community. You see, I am them. Fortunately for me, the combination of a loving family life as a child, my involvement with AA meetings, personal research into the biology of mental health and addictions, therapy, medication, meditation and a strong spiritual connection through aboriginal teachings and Buddhism have brought me here.

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In the search for truth, human beings take two steps forward and one step back. Suffering, mistakes and weariness of life thrust them back, but the thirst for truth and stubborn will drive them forward. And who knows? Perhaps they will reach the real truth at last. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Terrie, for coming forward with your story. That was excellent. You've left a little bit of time for questions. Helena?

Ms. Helena Jaczek: Terrie, thank you so much for coming and for sharing your story and also your recommendations. I think we've heard quite a bit about your recommendations already—the issue of peer support or a friend, someone to connect to. But we've also heard the need for—and I don't like the term, but I guess it's being labelled case management. You seem to have found your way, it sounded through your story, almost as an individual, and you've obviously had a lot of insight into your condition and so on. In this greater Sudbury area, do you see examples of case management that are working? Is it missing? How would you like to see that piece help others?

Ms. Terrie Pitfield: I think what's missing is—in this area, there is a lot of co-operation between agencies that do a lot of street outreach. I don't think everybody's on board in terms of harm reduction. There are no harm reduction policies in place. If people get it, things are sort of under the radar.

Ms. Helena Jaczek: We did hear from the Sudbury Action Centre for Youth. We were actually quite amazed by the numbers that they were seeing.

Ms. Terrie Pitfield: Yes. When I actually started working in this field, I started doing street outreach with them. Their harm reduction program has been going on for years. They do amazing work, but again, those agencies are very few and far between that openly have a harm reduction approach. I think it's still so misunderstood, what harm reduction means. People think that if you mention harm reduction, you're promoting drug use. We all know that drugs are going to be here for probably long after we are gone, so we need strategies and harm reduction programs that deal with the harm from those drugs.

The Chair (Mr. Kevin Daniel Flynn): Thank you. We'll move on to the next question, if it's okay with you, Terrie.

Ms. Terrie Pitfield: Sure.

The Chair (Mr. Kevin Daniel Flynn): Who's next? Sylvia?

Ms. Sylvia Jones: Thank you for coming in, Ms. Pitfield. I want to delve a little deeper into your experience with peer support. Obviously, AA—it's a huge component of their program. It's all volunteer-based. How do you formalize peer support, or how would you envision formalizing that role?

I didn't say it was going to be an easy question.

Ms. Terrie Pitfield: No. The support that I've received from people in AA has been phenomenal. Of course, the issue with AA and NA is that they are abstinence-based programs. Is it possible to create positions for professional friends? I don't know.

Ms. Sylvia Jones: Does peer support work because it is a "been there, done that" sounding board as opposed to, "I'm the expert; let me tell you how you must do it in order for you to recover"?

Ms. Terrie Pitfield: Absolutely. "Been there, done that"—that's exactly what it is. There is an understanding, I think, between drug addicts, alcoholics; we understand each other.

Ms. Sylvia Jones: And does that, by extension, go into, "One route is not the only route to recovery," with peer support?

Ms. Terrie Pitfield: Yes.

The Chair (Mr. Kevin Daniel Flynn): We have time for a very short question and answer, France. We have the Alzheimer Society on the line.

M^{me} France Gélinas: You are the first one who insists so much on including meditation in the treatment option. Where did it come from and why is it so important to you? If it's personal, you don't have to share.

Ms. Terrie Pitfield: No, absolutely not. There's one component I did not speak about. This is a partner who has been with me since I sobered up, so we've been together about 13 years. If it had not been—I'm angry with her right now because she's insisting I quit smoking, so I didn't want to include her in my presentation.

Ms. Sylvia Jones: You should listen to her.

Ms. Terrie Pitfield: I will.

She has literally forced me—and not wanting to lose that relationship—to look in other places for techniques that will help me heal, that will keep me sane, and meditation has been a godsend.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today. That was a wonderful story and I think you got your point across very well.

Ms. Terrie Pitfield: Good. Thank you.

ALZHEIMER SOCIETY, NORTH BAY AND DISTRICT

The Chair (Mr. Kevin Daniel Flynn): Waiting on the phone is the Alzheimer Society of North Bay and District.

Ms. Linda Brown: Yes, hello.

The Chair (Mr. Kevin Daniel Flynn): Hi, Linda. How are you?

Ms. Linda Brown: Very good. Can you hear us okay?

The Chair (Mr. Kevin Daniel Flynn): Yes, you're coming across like you were sitting in the room.

Ms. Linda Brown: Oh, that's good.

The Chair (Mr. Kevin Daniel Flynn): In fact, a friend of yours is sitting in the room. Patricia Montpetit is with us as well.

Ms. Linda Brown: Hi, Pat.

The Chair (Mr. Kevin Daniel Flynn): All members of the committee are here. I'm Kevin Flynn. I'm the Chair. Everybody has been getting 20 minutes to make their presentation. You can use that any way you see fit. If you can leave some time at the end for some questions and answers, that would be wonderful, but it's not necessary.

Ms. Linda Brown: Okay.

The Chair (Mr. Kevin Daniel Flynn): You're coming across really clearly right now. So if you're sitting in a comfortable place, stay right there. It's all yours.

Ms. Linda Brown: Mr. Chair, members of the select committee, ladies and gentlemen, we thank you for the privilege to speak with you today on behalf of the Alzheimer Society of North Bay and District. Let me introduce myself as Linda Brown, the executive director and the caregiver counsellor of the Alzheimer Society of North Bay and District, as well as my colleague Kathy Gaudaur, the education coordinator of the society.

Prevalence and impact: More than 180,000 people in Ontario have dementia and in less than 25 years the number will double. Dementia is the leading cause of disability in Ontarians over 60, causing more years lived with disability than stroke, cardiovascular disease and all forms of cancer.

Dementia has a dramatic impact on the health system as well. Persons with dementia use one third of alternate-level-of-care-bed days. Dementia is highly correlated with hip fractures, and persons with dementia occupy over 60% of our long-term homes; 57% of older persons

presenting at one emergency room had a cognitive impairment. Today, there is no cure. Dementia is fatal.

Our mission statement: Our mission at the society is to alleviate the personal and social consequences of Alzheimer disease and related disorders and to promote research. Our goal is to foster excellence in service, education and research.

What is dementia and Alzheimer's disease? Persons with Alzheimer's disease or dementia face stigma on a daily basis that is associated with mental illness and ageism. Our aged population quite often feels excluded and their value diminished because of how our society views the elders. We are all so busy, we sometimes not knowingly force these individuals into isolation.

Dementia symptoms include the loss of memory, judgment and reasoning. Changes in moods, behaviours and communication are also noticeable. These, in turn, affect the person's abilities to function properly in normal daily activities such as work and social interactions.

Alzheimer's disease, the most common form of dementia, is a progressive, degenerative disease of the brain, which causes thinking and memory to become seriously impaired.

The disease impact: The majority of clients on our caseloads have an average age of 70 years. They are living with a spouse of similar age or older. The spouse is usually assuming the majority of caregiving duties in the face of their own advancing age and ill health. Children who are caregivers for aging parents are usually in their 40s and 50s. They face daily stress by having to balance parental commitments to their own children and/or the demands of outside employment. Older caregivers often endure self-imposed isolation. This is because of the embarrassment and stigma created by the deterioration of personality and behavioural changes associated with the progressive and unrelenting course of the disease. When they do seek help, they are often in the midst of a full-blown crisis.

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Help and accessibility: Establishing a First Link referral process in the community can provide an early access for families into the system so that they could gain awareness of the disease. This allows them to plan effective coping strategies as their family member progressively degenerates with the disease. Part of effective planning and adoption of healthy coping patterns is knowing when and where to access the community resources that can offer relief. This will help decrease stress and avoid crisis that can unnecessarily lead to a premature facility placement for their individual family member.

The family's ability to access either in-home or day respite becomes a critical factor in prolonging a dementia person's continuance in their home environment. Respite care allows the caregiver time and freedom to pursue their own personal, social, and recreational endeavours. They can also involve themselves in caregiver support services and education that provide benefits from information sharing, strategy building and mutual support.

There is evidence that education, support, and counselling for caregivers can increase the length of time they can provide care for family members at home, delay death of the care recipient, improve interactions between caregivers and care recipients and significantly reduce depressive symptoms in caregivers.

People with dementia need more time to engage with in order to have them do their care with the least amount of stress and confusion possible. In the later stage of dementia or Alzheimer disease, we can see the physical effects of these illnesses but we can't see the mental and emotional effects. It takes time to get a simple message to be understood, such as personal health needs and nutritional needs. Agitation and mood changes can be experienced when trying to get someone with this disease to co-operate and help with any given task. As the communication diminishes, so does our emotional and mental contact diminish. Looking after someone with Alzheimer's disease or dementia becomes a heavy responsibility and can cause a great deal of stress on the caregiver.

Stigma versus diagnosis: Today we still see people waiting to seek medical help for their memory impairments. When you talk to these individuals, you notice that the fear of Alzheimer's disease kept them from seeking the medical attention needed early on. Many view this disease as a crazy person's illness linked to aging. It is viewed as a mental illness, and in part this opinion is correct. The person who has Alzheimer's disease or a related dementia suffers from short-term memory loss. They also lose the ability to do familiar tasks such as bathing and dressing properly for current weather conditions. They may wander or get disoriented when they leave their home even if they are just in the front yard. They forget names of family members or friends, and keeping a normal conversation becomes quite difficult. Persons suffering from this illness tend to isolate themselves, and caregivers, not knowing what to do, accept this isolation. Caregivers commonly don't tell friends, neighbours or family that their loved one suffers with a cognitive illness. They know if they do tell, it is common for friends, neighbours and family to become fearful and stay away. Now we have a situation where the caregiver is alone to face this disease, and the person who is ill usually is in denial. This, combined, will become a crisis situation in a short amount of time. With early diagnosis, there are medications that can help with behavioural issues, depression and mood changes. In turn, this makes the illness more manageable and can give longer stabilization with the disease.

The stigma of cognitive illness is noticeable particularly in smaller communities which are common in northern Ontario. People do not want neighbours knowing there is a loved one residing there with Alzheimer's disease or a related dementia. Helping these people takes time and becomes more of a challenge. Embarrassment and fear of judgment tend to create isolation and anxiety. People do not want other people to know when there are cognitive problems within their own family unit. It is surprising to see just how many people believe that

generally uneducated individuals are the ones affected by Alzheimer's disease.

Alzheimer's disease is frightening for the victim, caregivers and professionals. It is a progressive disease that we cannot really change, nor can we avoid the ultimate outcome.

Community health care cost-containment strategies, aggressive hospital discharge policies, limited day program spaces as well as an aging caregiver population have intensified the need for respite care over the last several years.

As the population ages, the number of individuals affected by Alzheimer's disease and related dementias is expected to increase dramatically over the coming years. The need for a coordinated response for all of those dealing with dementia is crucial.

Recreational activities, education and support services help those affected by the disease to maximize basic motor functioning and reasoning abilities, build confidence and socialize more effectively, as well as to plan for their future.

It is our pleasure to thank you for recognizing our efforts in providing the necessary services that assist our community in accepting and respecting the dignity of these people and their caregivers.

I'll now pass you through to Kathy Gaudaur, our education coordinator.

Ms. Kathy Gaudaur: Can you hear me okay?

The Chair (Mr. Kevin Daniel Flynn): That's good, Kathy.

Ms. Kathy Gaudaur: Thank you. If you look up the word "stigma," Wikipedia says, "Stigma is often based on ignorance, irrational or unfounded fears, mass hysteria, lack of education, or a lack of information pertaining to a particular person or group. Social stigma often leads to marginalization."

It's interesting to explore this definition as it pertains to Alzheimer's disease and related dementias. Stigma is often based on ignorance. There can be many misconceptions about Alzheimer's disease and related dementia due to ignorance. One misconception is that many people believe that once a person has Alzheimer's disease or dementia, they are living in a long-term-care facility. In actual truth, most Ontarians with dementia today are supported outside of institutions, in their own homes, with their families.

Stigma is often based on irrational or unfounded fears. Alzheimer's disease and related dementia are often mistaken as diseases that affect only old people. In actual fact 15%, or one in six, people with dementia are under the age of 65. It's interesting to note that as the baby boomers age, it's often said that 50 is now the new 40, and society generally portrays aging in a negative light.

Stigma is often based on mass hysteria. One excellent example of a stigma is the common belief that all old people get Alzheimer's disease or dementia. Alzheimer's disease is the most common form of dementia. It is a progressive, degenerative disease of the brain. It is not part of normal aging. That being said, as baby boomers

age with longer life expectancy rates, there certainly will be a rising tide of people, with Alzheimer's disease and dementias having an impact on Canadian society.

Stigma is often based on the lack of education. The Alzheimer Society strives to help educate people in the early stages of the disease, caregivers and family, professional caregivers and the general public. One study concluded that for every person affected by Alzheimer's disease, 10 to 12 others are directly impacted. These include caregivers such as family members, friends and neighbours, and employers and health care workers.

Stigma is often based on a lack of information pertaining to a particular person or group. Many families are embarrassed or feel a sense of failure if they place their loved one in a long-term-care facility. Often, when faced with a diagnosis of Alzheimer's disease or dementia, many families feel shame and try and hide their loved one from society. This action further isolates the care partners. Stress levels have been reported as three times greater in care partners of people with dementia as those caring for people with other chronic diseases, and depression is nearly twice as common.

Social stigma often leads to marginalization. Support groups and caregiver counselling can help keep patients with Alzheimer's disease and related dementia at home. One study found that a caregiver support program resulted in a 28% lower risk of nursing home placement compared with usual care. Caregiver support in Canada may depend on a network of the diagnosing doctor and on local resources and availability, which is why First Link is tailored to services in an individual community.

In conclusion, the written definition of "stigma" that I've tried to explain doesn't fully portray the difficulties faced by people diagnosed with Alzheimer's disease or related dementia.

Imagine sitting in a doctor's office with your spouse of 30 or 40 years and being told that you have a disease that will slowly rob you and your family of your life's work, future dreams and past memories over the next 10 or 15 years. There are no survivors.

Thank you.

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Ms. Linda Brown: We're open to any questions now that anybody may have.

The Chair (Mr. Kevin Daniel Flynn): Okay. Thank you, Kathy. Thank you, Linda.

We'll start with this side. Any questions from this side? Let's go to Sylvia.

Ms. Sylvia Jones: It's not so much a question as a statement. You're not the first committee that has raised the stigma relating to Alzheimer's. I guess I'm surprised that there is that much stigma associated with it. Maybe that's because personally I've been affected by it. But it amazes me that your focus and that of others presenting on behalf of Alzheimer's societies is that it is such an issue that you must overcome on an obviously regular basis.

Ms. Linda Brown: This is Linda talking. Yes, it is. I'm the executive director here at the society, but I also

do the counselling with families. I do the counselling in smaller communities as well. It's so amazing to see the people we are meeting, how they are still back in the olden days when you had a family member who had Alzheimer's disease and they did relate it as a crazy person's disease, where they automatically took that person and locked them up in the psychiatric hospital and they were never to be seen again. So there are a lot of people who are afraid to come forward when they're starting to have cognitive problems. They don't want their friends or their neighbours to know, because they are afraid that that's what people are going to think—"Oh, my God, there's mental illness in the home. Stay away. Keep your kids away, because there's a great amount of danger there"—when in fact that's not the case. That's why it's so important to get the education out there so that people know this is not the fact. This is a disease, it does cause a mental illness, but you don't have to be afraid of the person who has the disease.

Ms. Sylvia Jones: Thank you.

The Chair (Mr. Kevin Daniel Flynn): France and then Maria.

M^{me} France Gélinas: Thank you for your presentation, Linda. You mentioned that for a number of reasons—aggressive hospital discharge, limited day program space etc.—there is a need for respite care that has grown over the last several years. Why don't we put in place more respite? Is this a question of funding? And what types of respite work best, or are there a series of respite options that work best with people with Alzheimer's?

Ms. Linda Brown: I'd like to give you an answer for sure as to why there was not enough respite in the communities. Funding certainly is a big issue surrounding it, but the type of respite care that our clients are looking for—they really need to have somebody in the home to help with bathing issues and personal care issues, but they also need the break as well. If you're looking after somebody who has Alzheimer's disease, it's a 24/7 job, and quite often these people are up during the night as well. If you're up during the night with somebody who has an illness and then you have to be up during the day, it's not going to take very long before you're going to have burnout. So respite care is so, so relevant. We're not asking for 60 hours a week of respite care. The clients we have who are receiving up to 12 and 16 hours a day of respite care are happy with that and they're very grateful for that, but sometimes that's just not enough. Sometimes overnight respite would be great so that they could get a really good night's sleep.

We run support groups and education sessions, and quite often our clients can't make these groups at the times that we set out. We try to accommodate everybody, but it's very difficult to do. If we were able to access some respite services so that these people could come to our sessions, that would help as well, but that's not always looked at as a need to provide respite services in the home.

M^{me} France Gélinas: Where does the money come from right now for the respite that you do offer?

Ms. Linda Brown: Our agency itself does not offer respite services. The Alzheimer Society of North Bay doesn't have that. The people have to access the community care access centre or our community support services, and their funding comes through the LHIN.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Maria?

Mrs. Maria Van Bommel: In your presentation you talked about the education, support and counselling for caregivers that would increase the length of time that they could provide care for their family member, but I was also glad to hear you say you're caring for the caregiver. My husband has been involved with the VON. On a volunteer basis, he would visit with the Alzheimer's patients at their homes. But he found over time that very often, although the intent was that he would stay and give some respite to the caregiver, the caregiver actually, over time, had lost all social contact with friends. He provided as much social—actually, he probably provided more social activity and conversation with another adult for the caregiver than actual help with the Alzheimer's patient.

So I was glad, and that was my question to you: What kinds of programs have you got for the caregivers to help them take care of themselves and keep up their social contacts and do that sort of thing? It's not just about going out and having time to go get the groceries, or maybe even a night's sleep, but just that whole social aspect of being a caregiver who gets isolated because they're doing this 24/7.

Ms. Linda Brown: A couple of things that we do—first of all, the support group does allow them an opportunity to come and meet other individuals who are going through the same thing as they are. I can tell you, from running my support group, sometimes we enter into a group and the only thing we do is cry, perhaps, for an hour and a half, whether it be for a loss of somebody who has Alzheimer's disease or just for the loss of a life that people have built together. Sometimes we go into that session and we just laugh for an hour and a half because that's what we need to do. Friendships are made and support systems are made. Those are very, very important.

Here at the agency, we run a teddy bear club in which we try to get some of our caregivers together once a month, or whatever they can, to knit and crochet. What we do is we crochet these teddy bears and we hand them out around the holiday time to long-term-care homes and to hospitals. These teddy bears are like a therapeutic item. They offer comfort and a form of security to people who have Alzheimer's disease.

We're also taking a look at starting an art therapy program. This is going to be for individuals with Alzheimer's disease, but it's going to be a way for caregivers to come out as well, in a different kind of environment where there's more socialization. It's very, very difficult to get caregivers out on any form of a regular basis because a lot of them can't go out on their own. They have to have somebody staying with their loved one. This is where the difficulty sometimes arises. Out of a group of 10, you might be able to get three to come out for

something, for an event, at the same time, and the next time you might get a different three. It just really depends on the circumstances at home and how much time they can afford to get somebody in to look after their loved one while they're out at an event.

The Chair (Mr. Kevin Daniel Flynn): Speaking of time, Linda and Kathy, we're out of it.

Ms. Linda Brown: Oh. I was just getting into it.

The Chair (Mr. Kevin Daniel Flynn): I know. I could tell you were on a roll there. I didn't want to jump in. Thank you very much for joining us this afternoon.

Ms. Linda Brown: Thank you very much for giving us this opportunity. We really do appreciate it.

Ms. Kathy Gaudaur: Thank you so much.

LORIE BELL

The Chair (Mr. Kevin Daniel Flynn): Our next presenter this afternoon is Lorie Bell. Lorie, if you'd like to come forward. Thanks for accommodating our phone call there. Just make yourself comfortable. You've got 20 minutes, like everybody else. Use that any way you see fit.

Ms. Lorie Bell: Do I have to put the mike on?

The Chair (Mr. Kevin Daniel Flynn): The mike will turn itself on. You just have to have good thoughts and then the light comes on.

Ms. Lorie Bell: Oh, there you go.

The Chair (Mr. Kevin Daniel Flynn): If the light doesn't come on, I don't know what that means. If you stay about a foot away from it, it works great.

1430

Ms. Lorie Bell: Okay. Hello. My name is Lorie Bell and I work as a concurrent worker in the transitional outpatient program at the Sudbury Regional Hospital, mental health and addictions. However, I'm not going to be presenting on that because my colleague, I heard, did a wonderful presentation on our program and another colleague did one on the concurrent. So I'm going to be presenting as an aboriginal citizen who lives in Sudbury. I'd like to talk about my vision of what I would like to see from consulting and speaking with other aboriginal people in the area.

I had many ideas when I began this, but was able to find my general themes as partnership building, cultural space and education research. I am presenting the general comments I have heard from the aboriginal community in Sudbury over the last few years. Many are based on the concept of connected services that are all on the same page.

Partnerships: The aboriginal community in Sudbury is interconnected, and the feedback I am getting from the aboriginal community is that we need to work in partnership with Shkagamik-Kwe Health Centre native mental health program and N'Swakamok Friendship Centre addiction programming to develop and enhance the understanding of concurrent programming to meet the needs more effectively.

I am proposing an allocation of funding to provide a safe cultural space and human resources within the Sudbury hospital's outpatient services in order to create a bridge between our services to address increasing aboriginal populations and plan preventive strategies to service the increasing aboriginal youth populations. As you are aware, the mainstream populations are aging, and planning is under way to prepare for this increase in services to deal with this. However, there's a rapid increase in aboriginal youth and we need to prepare services for that as well. This partnership will allow us to build on our strengths and decrease any duplicate services that may be in the area.

The next theme I had was an educational initiative to enhance best practices for aboriginal services within cultural-specific programming and mainstream programming.

Another area of concern is the focus on evidence-based practice. Although many aboriginal people want evidence-based practice, there is a great concern about the studies conducted that may have excluded aboriginal populations and thus would not be applicable in some cases. Although there are features of cognitive behavioural therapy in many holistic approaches to healing, they are generally interwoven through a process and there is not such a strong focus on the manualized content, but rather the relational aspects would be of primary concern.

With this in mind, I am proposing a collaboration of partnerships with the Sudbury Regional Hospital mental health and addictions services, Shkagamik-Kwe Health Centre and N'Swakamok Native Friendship Centre to work in partnership with the native human services and native studies department at Laurentian University to develop case study research to identify best practices within aboriginal populations in northern Ontario. As you are aware, this type of initiative cannot be achieved without funding for a researcher.

Implementing a specific space for aboriginal people to utilize the mental health and addiction outpatient services: Align the spiritual with the emotional, mental and physical holistic healing. Many, if not most, studies have identified a holistic manner of healing for aboriginal populations. In order for that to be achieved, particularly in the mental health and addictions area, a safe cultural space is necessary to practise the spiritual aspect of our healing, a space which will allow aboriginal people utilizing our services to smudge, which is the use of sacred medicines, which in some cases means burning medicine in a safe smudge bowl. This space can also act as a visual symbol of inclusiveness for aboriginal people.

Of course, by now you are wondering how much this will cost, I'm assuming. I think it's a good investment that will pay off. When one segment of the population is overrepresented in almost every area of the system, we are all affected and there is disharmony within the groups.

The next was relationship-building with aboriginal inmates at the Sudbury District Jail. Although the jail

does have medical services, they are not designed for mental health and addiction treatment. I believe we could also partner with the native healing program and make the referral to our organization smoother. A high percentage of aboriginal people are in jail as a result of mental health and addiction issues and they are falling through the cracks. We have an opportunity to provide education regarding concurrent issues and develop relationships to motivate some of them to access our services and thus decrease the revolving door within the jails. Of course, this would require the allocation of at least one employee to go to the jail and work with the medical and native liaison services to assist in the process.

Lastly, I'd like to request that more monies be invested in DVDs and literature for people who are developmentally delayed or illiterate. When people are facing these challenges it is very favourable to their recovery to be able to direct them to literature that is specific to their presenting issues. Unfortunately, we are often not able to offer these services to people who are not able to read at a college or university level. I would especially like to see more materials developed for concurrent recovery.

With that, I would like to say meegwetch and thank you for your time and consideration in allocating funds to build strong partnerships with the aboriginal agencies providing similar services in Sudbury and for your consideration of grounding these partnerships in research, education, infrastructure and the inclusiveness of our worldview on healing practices.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Lorie. That was a great presentation. You've got some time for questions, and we're going to start with France.

Ms. Lorie Bell: I'll try my best.

M^{me} France Gélinas: Thanks, Lorie. Nice to see you.

I wanted to ask you: You identified, under "An Educational Initiative," "identify best practices within aboriginal populations in northern Ontario." Another presenter, this morning, who comes from an AHAC, an aboriginal health access centre, mentioned that she would like to see a symposium where we would gather all the best and brightest minds to put together best practices in mental health for aboriginal people. I was wondering what you think of that idea.

Ms. Lorie Bell: I think that's a wonderful idea as well. The reason I came to this conclusion is because we have a wonderful university here in Sudbury and a wonderful program. The BSW is in native human services, and there are only two programs like that in Canada, and the native studies. So they are training social workers there to go into the field. I thought it would act as a multi-level part of developing case studies in the work that we do and, at the same time, training the new social workers and exposing them to the environment at a hospital. I was thinking along those lines, but the other area is good too.

Our issues are a little different from southern Ontario's. Sometimes when we do come all together like that—we're all different groups, so we don't quite get the

same information as we might if we were in the northern Ontario area, I was thinking.

M^{me} France Gélinas: And Laurentian University sounds like a good ground to you?

Ms. Lorie Bell: It does, yes. I graduated from that program years ago and it was a very empowering experience where aboriginal people were encouraged to heal themselves before they go out into the workforce and work with people, and that was stressed. So the healing methodologies were done right there in the school to make sure that you were okay before you went out there. I've had a close relationship with them and all the new graduates coming out since then. I won't tell you the date.

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M^{me} France Gélinas: That's okay. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Any questions from this side? Maria?

Mrs. Maria Van Bommel: Your concept of having a cultural space within the hospital is something new to me. This is the first time I've ever heard anyone talk about doing it. We did see it actually at Moose Factory in their hospital, where they had a traditional healing area, but in the mainstream general hospital thing I hadn't ever really envisioned anything quite like that, although quite honestly we have chapels in our hospitals that allow for that.

When you talk about it, would that really be a very expensive thing to do because, like you say, it really is just a matter of proper ventilation for the smudge pot and that sort of thing?

Ms. Lorie Bell: And an actual room. We're kind of bursting at the seams right now in terms of our space and resources. I don't imagine it would be too expensive to do, but we would—

Mrs. Maria Van Bommel: But where would you do that? Would you do that in all hospitals or would you do that where there's a significant aboriginal population in the area?

Ms. Lorie Bell: I certainly think where there's a significant aboriginal population in the area—and although we do have Shkagamik-Kwe Health Centre. It's a different service. Ours provides treatment. We're focused on mental health and addiction treatment, so we're not just emergency services or a clinic per se.

Mrs. Maria Van Bommel: Thank you.

M^{me} France Gélinas: The Sudbury Regional Hospital is under redevelopment right now. It is scheduled to be finished in April. They have a smudge room. They have a traditional herbs cabinet and they will be able to provide traditional healing and traditional treatment in a culturally appropriate environment. It's a beautiful room. It's not open yet because it's under construction.

Mrs. Maria Van Bommel: So when did that become part of the planning process? That would have had—

M^{me} France Gélinas: Way back, 10 years ago.

Mrs. Maria Van Bommel: So, 10 years ago it was decided that there would be such a room?

M^{me} France Gélinas: And it took that time to get it built. Dr. Koka is laughing because he's been in the planning stage for the last 20 years.

Ms. Lorie Bell: I'm looking at the outpatient mental health addiction services, which is a part of the hospital.

The Chair (Mr. Kevin Daniel Flynn): Christine or Sylvia?

Mrs. Christine Elliott: Thank you very much, Lorie, for joining us today. I really appreciate your insights. One thing that you've touched on that we've heard a lot of about is that there are a lot of people with mental health and addiction problems in correctional facilities and we haven't heard much about solutions for that, never mind aboriginal populations in those facilities. Could you tell me how that works now? Does the John Howard Society facilitate discharge or working with people? How is it now and how would you like it to be?

Ms. Lorie Bell: I certainly don't want to take away from the good work that John Howard does or Elizabeth Fry. They certainly do good work with them. They also have a wonderful native healing program in there that has been going on for quite a long time.

My awareness of the aboriginal inmates came when I began doing educational programming for them in terms of prevention of HIV, hepatitis C and things like that. After doing that for such a long time, I heard a lot of stories of trauma, a lot of stories of childhood abuse and addiction, the lack of support and the lack of understanding of mental health symptoms and almost a normalized view of addiction for people. But I think I may have gone off what your question was.

Mrs. Christine Elliott: No, I think I understand that there really isn't that specialized understanding ability to work with those issues that people need to deal with. They're dealing with housing issues and getting people back out into the community and perhaps medical needs, but I'm getting the sense not maybe mental health needs in a culturally appropriate way.

Ms. Lorie Bell: Yeah. This is what I'm thinking. Those basic needs are probably getting met by those services, but for actual mental health treatment and addiction treatment programming, besides being referred to treatment centres, like my colleague said earlier, that's not always the solution. Sometimes it's good to keep them in the community working through an outpatient program. I don't believe that's available for them.

Mrs. Christine Elliott: A big gap, then.

Ms. Lorie Bell: Yes.

The Chair (Mr. Kevin Daniel Flynn): Lorie, there was a lot in your presentation about what you need. I was just wondering, what do you have to give? The reason I'm saying that is that I know, for example, that a lot of psychologists now are using mindfulness as part of their treatment, and a lot of that is based on the Buddhist faith, and it's used by people who aren't necessarily of the Buddhist faith.

Ms. Lorie Bell: That's right.

The Chair (Mr. Kevin Daniel Flynn): I'm just wondering what the general population of North America

that is experiencing a lot of mental health issues can learn from its aboriginal peoples.

Ms. Lorie Bell: Actually, I'm glad you asked me that because I do attend ceremonies and participate in a culture as well as work with it.

We do have an increasing number of non-aboriginal people coming to us and wanting to be part of the sweat lodge and wanting to sit in the healing circles and to smudge and to help, to know where that centre is, to get connected to their whole self.

What we don't do is push the spiritual part on anyone. We identify what we do, but that choice is always there, for people to choose, particularly with the historical pain that some people have experienced from that area. Yes, so we do; we have people coming to the sweat lodge and healing circles. I'm pretty sure non-aboriginal people are able to access the traditional medicine person at Shkagamik-Kwe Health Centre and all the other services that they have, like the drum making, which is a part of the therapy too, to rebuild. So it's quite open.

To be honest with you, not all aboriginal people are open, but some are. That would be the only place that I would send people to, where someone is open and respectful.

The Chair (Mr. Kevin Daniel Flynn): That's wonderful. Thank you very much for coming out today. That was a great presentation, very enlightening.

Ms. Lorie Bell: Thank you very much.

DR. RAYUDU KOKA

The Chair (Mr. Kevin Daniel Flynn): Our next speaker today is Dr. Koka, if you'd like to come forward, sir.

M^{me} France Gélinas: You missed Maureen McLelland?

The Chair (Mr. Kevin Daniel Flynn): No, Maureen's at 3. We've moved Dr. Koka up from 4.

M^{me} France Gélinas: Okay.

The Chair (Mr. Kevin Daniel Flynn): That's right. I've got it all figured out. How are you doing?

Dr. Rayudu Koka: That's true, Mr. Chair. We did change it.

The Chair (Mr. Kevin Daniel Flynn): They're keeping me on my toes here, Doctor.

Everybody has 20 minutes; you've got 20 minutes. You can do anything you like with that 20 minutes. If you could leave—

Interjection.

The Chair (Mr. Kevin Daniel Flynn): Yes, that's right. If you could leave some time at the end for some sort of a discussion, that seems to work best. Other than that, the time is all yours.

Dr. Rayudu Koka: It may be a mistake to say that I can do anything.

M^{me} France Gélinas: You've obviously never met Dr. Koka.

The Chair (Mr. Kevin Daniel Flynn): Is that right? All right. I can't wait to see this, then.

Dr. Rayudu Koka: First of all, Mr. Chair, thank you very much, yourself and all the honourable members who are here, for coming to Sudbury and giving us the opportunity to present this, to me, very important matter, very dear to my heart.

As I stated in my presentation, I'm Rayudu Koka. I'm a psychiatrist here. I've been here for 23 years. I came straight here from the UK. I'm staying here and nobody's going to take me anywhere. I'm a proud Sudburian.

I'm part of the department of psychiatry; I'm medical director of the program here. I'm also an associate professor at the new Northern Ontario School of Medicine, and I'm section leader for psychiatry.

I'm also a very actively practising psychiatrist, although I do a lot of other things. I have in-patient/out-patient community psychiatry and outreach programs that I do. As I said, I do clinics at Elliot Lake, Blind River and Sucker Creek, otherwise called Aundeck Omnikaning First Nation community. I've provided services to these communities for the last 20 years.

I have 12 adult psychiatrists in my department and one child psychiatrist. We provide service to a population of about 250,000. That is one psychiatrist for every 20,000 people. In comparison, if I may say so, Mr. Chair, for Toronto it's about one psychiatrist for every 3,500, I believe. Is it because they have more mental illness? I'm not sure.

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I have been a strong advocate for a number of years with regard to mental health and I still continue to pursue that route.

I think this document on the 10-year strategy by the Honourable David Caplan and the team is a welcome opportunity for our mentally ill population. I'm going to represent on their behalf more than anything else. It's a very good document, a lot of good ideas. He's taken a very personal interest in mental illness and addictions. That's great. I hope there will be meat and potatoes provided to give the service that we need for our patients. All of the LHINs except one had the highest priority for mental health, which is a good thing.

I'm going to be speaking on mental health issues. I'm sure all of us in this room have had some impact on us through family, friends or ourselves having had exposure to mental illness and the enormous effects one may have experienced. We all know that, and I don't have to tell you about this.

First of all, I of course welcome this on behalf of the patients and also the colleagues of mine. Also, I think that integration and collaboration are the most important things in this day and age. We have to collaborate, co-operate and work together with different programs and primary care. I think psychiatry has been in the lead with regard to collaborative care while the other ones are trying to do it now. We can probably enhance that part—collaboration and integration.

I must say that we had two organizations here a few years ago. Through public support we managed to get them integrated into one organization with one board of

governance, one administrative structure. Now it is a one-stop shop for the other mental health programs in our community together under addictions. It is a great success, and I think my colleague Maureen McLelland will be talking about it more. I want to concentrate on this now.

I think the gaps with this integration, what we have experienced, of course are: We'll need more for our homes for specialized care; supportive housing with minimal supervision; more case management programs; more counselling and treatment services; psychological rehabilitation programs; day treatment programs; also, most of the patients are on disability pension or Ontario Works, so they need some transportation facilities as well; and some employment work opportunities and training opportunities.

It's amazing. I'll just tell you one story. This morning I saw one of my patients. There's a gender identity problem. She is a female, dressed as a female for the last two years, functioning in the community. Then we sent her to the clinic for the second-time follow-up visit to CAMH. They said she was following everything. They said, "You have to be working before we can do anything for you." So she goes to apply anywhere, they see her dressed as a female and won't give her a job. That is a terrible thing for this woman who wants to be female, who wants to get something done for her, and she cannot get anything done.

This afternoon I saw her. I've been seeing her for the last two years. Nothing is done and she's discouraged, depressed. She had been to Toronto about three weeks ago, and that's why I saw her today.

These are the kinds of things we need to try to somehow accommodate our patients on. I'm sure the same thing happens with other patients who have mental illness. They can't get jobs, and for a recovery model we need them to get jobs and be functioning normally.

I note that the minister stated somewhere in the document that we can do it without any further increase of resources. I don't know how we can do it. We are already lean meat projects in the mental health system, at least in my place. We can only do it properly if we freeze the programs or we cancel the programs—no more enhancements or further development, I think. One of the leading psychiatrists from Alberta, Dr. Bland, has produced in the Canadian Journal of Psychiatry. He showed that Ontario lags behind all of the provinces except Saskatchewan in terms of total percentage of health care funding directed towards mental health services, and it is far below mental health funding compared to other countries such as Australia. We believe successive governments over the years have not paid much attention to mental health funding, and that's where we are today.

We appreciate that this government is trying to put some money in here and there but is not ready to commit to be able to provide desirable adequate services to our patients and families. We have a lot of catching up to do, Mr. Chair. Kudos to anybody who can say that yes, we can provide service without increasing the resources,

financial or otherwise, because we'll be needing more. In this document we say we have to do case finding and screening and more early diagnosis, early finding of the cases. If we all do that, we need more resources rather than less resources or the same resources, because we're already under-resourced now. That's what I wanted to bring to your attention.

What happened in the last decade with the Putting People First document—it was just mind-boggling to us. We're just hitting our heads against the wall whenever we say we want to provide service to these moderately depressed patients. No, no, our funding doesn't allow that. We can care for only the seriously mentally ill. That was the problem we had. In this document, at least they talk about all illnesses put together. That's great. We appreciate and welcome that recommendation from this group. If we're going to treat all these cases, and we need services to meet the needs of this group, then of course we need more resources; definitely.

Prevention is an excellent idea. Of course I've been talking about it to my police chiefs and others in the city. How can we do this? We have to go to schools and start with kids, from early life, educating them about mental illness and mental health issues. Again, for the families of children of mentally ill, we have no way to provide service. These are all the things that we can do with regard to prevention of mental illness, and to try and help them early on to recognize some of the risk factors and what can be done. Educating, again, is important, both employers and employees and all areas.

Primary care and collaborative care: As I mentioned before, the family health teams and family health programs are helpful, but we need more and to do more in other settings also. Somehow, if we can have access to programs through other disciplines for psychiatrists in the communities maybe, or in the hospital systems we need more—so that they can concentrate more on diagnosing and treating the seriously mentally ill, or even get the primary diagnosis done and then pass it on to other disciplines, including primary care physicians. Primary care physicians don't want to take any mentally ill patients, because of their reasons—I don't have to explain; I'm sure you all know about it. If you ask me, I can talk about it later on. I think it may help if we can include mental illness in the chronic disease management programs, like diabetes and management of other cases.

Integration of children's services: Again, I really applaud this document including getting all the ministries together: the correctional system I already mentioned, children's services, MCYS, all included. In our own community we have a big problem. In the last two years our children's services have been separated for various reasons and more political reasons. We're trying to get them back together with the adult mental health system as it was before, but we're not able to. It costs more money. We cannot get the access to children's services. Although they stay in the same city, they won't provide any service to the emergency department because they're different organizations, different governance. They say their mandate is different, but anyhow.

Those are the things that are happening, so if we can integrate them when they reach 16 and onwards, we can also transition these people into the adult mental health system for the severely mentally ill group. I think it's important that we try to recommend this across the board.

1500

Person-directed or family-centred approaches: Of course, we always follow this philosophy in our programs here. We called it client-centred, but now we can say "person-centred," as in the document, and family-centred approaches as well. Families are very important in supporting the patients. Just this afternoon, before I came here, I saw a teacher who has bipolar disorder. The husband is a retired college professor. He has been such a tremendous support to her, so she's managed in the community in spite of the bipolar disorder. She was telling me today, "Dr. Koka, I'm feeling better today. Now I'm able to cook a little bit and do things, more than what I've ever done before." I said, "Your husband must be very pleased about that." So those are the things that are very important—for the family to be supportive. Family is a very important part.

On occasion, we have problems with families, in the sense that patients don't want us to do anything with the families. That's a problem we have sometimes. If you can do something to help us get family access somehow without getting us into trouble with the law, that would be appreciated.

Peer support, the role of physicians—diagnosis and treatment: I accept what is mentioned about the patient's role, the family's role and the peer support programs. In fact, I work with the ACT team also. I have a bipolar disorder patient with substance abuse problems. I've been seeing him for the last 15, 20 years. He came from out west and now he works in our ACT team as a peer support worker. He's a fantastic worker. He has kept well, he takes his medication and follows up—fine. We support them. He does help when I go on home visits with him. He says, "Look, I am one of them. Look how I am. You can be helped the same way." That helps a lot when we go to provide services to these patients because they get more insight and they can relate to them.

But at the same time, we cannot say they'll be able to diagnose and treat. You need somebody with expertise in diagnosing and treating because there could be somebody who has a thyroid problem and they can present as being depressed and withdrawn. Unless you recognize and treat that medical problem—they cannot, so you need a medical background, training and experience.

There have been cuts in services in residency programs in the past. We need more psychiatrists in the field. We don't have enough of them, so we need to attract them to the field of psychiatry. Being a teacher and an examiner for a while in college, I know how difficult it is to get these people in. So we need to do something about it.

There are gaps in services. I must say it is difficult to get primary care physicians for psychiatry patients. I'd mentioned that. We can do something. What we do in our

program here is, we have a family physician to whom we pay a stipend for him to come and provide a clinic in the hospital. In our community, we have 30,000, 40,000 people who don't have family physicians, especially our patients—90% of them don't have a family physician. So we help them by providing primary care through that route.

Aboriginal communities: Again, when I go there, they say, "We want more services, but we don't have funding," because they're federally funded programs and they don't have enough funds to get psychiatrists to the communities to provide their services. So if anything could be done through our programs here, it would be appreciated. I think my friend mentioned aboriginal programs earlier on.

Medication coverage: I'll give you an example. A patient of mine, a chronic schizophrenic, has two kids. He takes care of them because mom has gone away somewhere else. He does function well. This gentleman has a cholesterol problem. He doesn't want to take pills because he can't afford them. He has got hypertension but he doesn't want to take the pills. I want him to go for blood tests; he doesn't want to go for blood tests, and I cannot force him because he's competent enough to make the decision, and he can't afford them.

He can have a stroke. He has diabetes. He can get all the complications, but because he's on CPP, not ODSP, he can't get—I wrote a letter to the ODSP people and they said, "No, we can't." If anything can be done for those people, those low-income people who are working, those who are on unemployment benefits or CPP, it would be helpful.

In conclusion, I say I support this document. It's very well put together. I'm sure a lot of people will be supporting this and also giving some suggestions. Collaborative care is excellent. Integration, of course, is the way to go. Removing barriers from children's services, adult services and seniors' programs is great. We believe we need adequate resources that should be put in.

I think in mental illness, the patients' peers and families have a role to play. Other health care professionals can be of assistance in screening and further assessments and diagnostic help—for example, psychological assessment for personality disorders or the OT placement. These things are helpful. They also provide an important treatment team.

In conclusion, I would be happy to work with the government. I've also been section chair of psychiatry at the OMA.

I'd be happy to take any questions. I speak fast, I guess, because I wanted to get through a lot of stuff.

The Chair (Mr. Kevin Daniel Flynn): Well, you did go through a lot of stuff, and you left a little bit of time for questions. We've maybe got time for one—unless you give short answers. Christine or Sylvia?

Dr. Rayudu Koka: I'll try.

The Chair (Mr. Kevin Daniel Flynn): But you're a psychiatrist, so you probably don't.

Ms. Sylvia Jones: You did an excellent job summarizing a lot of what we've been hearing the last number of days.

I wanted to touch specifically on the fact that you have one child psychiatrist.

Earlier today, we heard of a Sudbury district school board saying that they had not been able to access child psychiatry for seven years. Where's the disconnect there?

M^{me} France Gélinas: It was a francophone boy. The child psychiatrist didn't speak French.

Ms. Sylvia Jones: Merci.

Dr. Rayudu Koka: There are two child psychiatrists with the Northeast Mental Health Centre, which is a regional program. That's where we have a disconnect. We don't have any contact or connection with them within the last two years.

We don't have any francophone psychiatrists. I went to Quebec and also signed an agreement, but we were not able to get them. It's very difficult to get child psychiatrists here—any francophone psychiatrists. I've been trying hard. That's where the problem is, I guess.

We have one child psychiatrist in our program, so we're trying to recruit more.

The Chair (Mr. Kevin Daniel Flynn): One small one, France.

M^{me} France Gélinas: Okay, we'll try for a yes or no, but I don't think it'll go. We've heard many times that family physicians are reluctant—all sorts of adjectives have been used, but at the end of the day, they're not seeing clients with mental health diseases. Do you solely put it on money, or are there other reasons why family physicians don't get involved with mental health?

Dr. Rayudu Koka: I don't think money is the only reason, because we have some provision for the money and they're not taking them. Comfort, I guess, is one. The newer physicians who are trained now are better trained and they're more comfortable in managing them.

I think it's a combination of things. Time is one and money is one, and they don't want to take too much trouble. Even, for example, in the ACT team, what we have for patients in my ACT team is we provide 24-hour, 365-day psychiatry service to them, backup. When I tell my family physician colleagues, "Look, if you take these patients, you don't have to worry about any kind of psychiatry problems. Just treat their physical health problems," there are still no takers.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Doctor. We really appreciate it. Thanks for your time today.

Mrs. Liz Sandals: Can I ask a question?

The Chair (Mr. Kevin Daniel Flynn): Oh, a very short question. What time is our plane?

The Clerk of the Committee (Ms. Susan Sourial): Five.

The Chair (Mr. Kevin Daniel Flynn): Okay, a very short one.

Mrs. Liz Sandals: I'm really interested in your comment around the integration of children's services and the fact that you can't get children's services in

emergency. I think from what we've heard previously about your outpatient services, they're adult outpatient services. How would you fix this problem?

Dr. Rayudu Koka: Well, I have written to the minister about it suggesting that we should try and integrate those services back into the adult programs. We used to provide an on-call service for the children's services as backup. It would save a lot of money. We used to provide on-call services in the emergency department as adult psychiatric backup. In collaboration together, we could function quite well and provide service integration. I have advocated and requested, and hopefully that will happen. We had a study done from Ottawa and they recommended what to do, what might be the best option, so that is one of the recommendations as well.

1510

Mrs. Liz Sandals: Okay. A technical follow-up: Is it because it's specifically not funded at the hospital to do this backup or is it because of the general problem that children's mental health is at one ministry and adult mental health is at another ministry?

Dr. Rayudu Koka: That didn't matter, I think; it was more locally here. Governance and administration is with one different organization. If that could be with, say, a Sudbury Regional Hospital transfer—we're building a centre of excellence for pediatrics as well. So with all this, that makes sense, to integrate what children's services are in Sudbury—we provide service for the whole of northeastern Ontario if it is with the regional hospital. Because it is Northeast Mental Health Centre of North Bay, we are not in connection with them, so that's what happens. If we can transfer the governance or administration to one side, it's solved, easy, with a lot of cost saving.

The Chair (Mr. Kevin Daniel Flynn): Thank you for coming today.

MAUREEN McLELLAND

The Chair (Mr. Kevin Daniel Flynn): Okay. Just so everybody knows, the bus leaves for the airport at 3:45. So our final speaker for the day is Maureen McLelland. Thanks for sitting through all the others. You've got 20 minutes like everybody else; use that any way you want. It's all yours.

Ms. Maureen McLelland: I'll try to tie together some of the themes from the last few presentations that I've been listening to. Thank you for the opportunity to speak. I'm speaking as an administrator of a large multi-site, multi-faceted mental health and addictions program. Colleagues have spoken before me, and I can talk a little bit more about integration opportunities and some of the successes that have happened with integration.

I'm a registered nurse by training, with 23 years of nursing background, and most of that career has been spent working with marginalized and stigmatized individuals—HIV and AIDS patients, injection drug users, people who have been victims of sexual assault and domestic violence. All of that experience leads me to be

in a position, now working in a mental health and addictions program, where it really does all tie together. If you think about the tragic things that happen early in your life, it doesn't stay buried for very long. It starts to bubble up, and as an adult it comes out in various ways, often as a mental health issue or an addictions disorder.

I'm very pleased to see that this is an inter-ministerial committee looking at ways to work smarter for the people of Ontario.

Who we are: Sudbury Regional Hospital's mental health and addictions program is a two-year-old program. We have a rich tradition of history with the previous district programs that were attached to Network North, Northeast Mental Health Centre and Sudbury Regional. Two years ago, by direction of Minister Smitherman, they were brought together under one single lead agency responsible for the treatment of mental health and addictions in the district of Sudbury-Manitoulin.

We have about 300 staff working in our program on a variety of sites. We're in 10 locations. We've got inpatient beds on two sites and we've got eight community programs. In each of those sites it's a completely integrated program; it's a mental health and addictions program. We don't separate: "Mental health goes through this door and addictions goes through this door." It's one door, it's one system, it's one staff, and I'll talk a little bit about our successes with that.

We are a district service, so we serve Sudbury-Manitoulin district, with about 250,000 people in our catchment area and a fair bit of geography to cover when you look at where our employees work and where our clients live.

Since 2002 there have been some targeted investments in mental health, and I've listed where those have happened. These are some of the programs that we operate through our integrated mental health and addictions program, but there's been a large investment in crisis intervention. It allowed us to make our service run 24 hours a day, seven days a week, 365 days a year. We have a mobile component where we partner with the police.

We have safe beds in the community now that weren't there before. Safe beds are a diversion away from hospital. If somebody needs to have a safe place but are not necessarily in such acute distress that they need to come to hospital, we're using safe beds.

Early intervention for psychosis has been an investment in the province. We used some of the funding for early intervention to direct to our postpartum population. Women with postpartum disorders need an awful lot of early intervention, and it's a very good illustration of how intervening early can change a life.

We've expanded our eating disorder services with these investments, intensified case management services and have streamlined access through a central intake for mental health and addictions. We've added peer support to our ACT teams, and Dr. Koka spoke about that, just the meaningfulness of being able to have a lived experience and contribute to the healing of others. And

we've expanded rapid response for seniors, so the presentation on Alzheimer's disease—our seniors' outreach team actually works as the treatment team for those with Alzheimer's and other age-related disorders.

Despite that, there are some community gaps that we still see. I sit at a district table, a table of other health providers and social service providers, and there are some really big issues that we still, despite funding, are not addressing effectively in the community.

Lack of access to primary care—Dr. Koka spoke about that. Just a little story I'd like to share: I've got a friend who has struggled over the years with depression, anxiety and alcoholism, and recently her family physician retired. She's a woman in her mid- to late forties. She's got two kids and a husband, and they had to be interviewed by a GP to be considered to be accepted into that GP's practice. The husband and the two kids were accepted into the practice and she wasn't. I think that's, first of all, a disgraceful thing to have happened, but to try to explain to her kids why that happened is hard to put into words. So it is happening in our community, that there is this sifting and sorting of who gets to see a family doctor and who doesn't.

We have a lack of access to affordable housing, and Dr. Koka has mentioned that. I'm not going to belabour the point.

I guess from a treatment perspective, and that's what our role is, we've got a long, long waiting list for treatment of serious mental illness—particularly mood disorders, so I'm talking about depression, anxiety and bipolar—as well as no in-patient services whatsoever for people suffering from eating disorders. We're flying people out of this community who are deathly ill and have nothing to offer them in terms of intensive eating disorder treatment.

What is working: We talked about vertical integration. By vertical integration, I mean we have a very seamless system at all of the levels of care, community flowing quite nicely into hospital and quite nicely back out again. So to have all of that under one organizational lead is making a big difference for our patients and families. They're not having to tell their story twice or three times or four times. We've got an electronic record that allows that information to be shared quite nicely, and I think vertical integration is really working in our community.

We've also done a lot of horizontal integration, and by that I mean all of these various little small teams with all of these little funding pockets have been collocated. So we have a building right downtown here in Sudbury, a seven-floor office building with many programs and services. We're seeing several hundred people a day coming through those doors for a variety of treatment groups, case management support, family support etc. So having everything in one stop, directly across from the bus station, is a really important message to the community that we belong on the main street and that we shouldn't be in the back alleys of Sudbury, two stops away from the nearest bus.

Being in one place has allowed us to really increase our ability to collaborate on treatment planning for

people with mental health and addiction. So lots of good stuff happens with hallway conversations: "I have a client; you have this expertise. Can you help me develop a treatment plan that would consider his needs?" And so there's a lot of synergy that happens when you move people together under one roof.

We also have collocated mental health and addictions staff in communities outside Sudbury, on the island, Manitoulin Island, in Elliot Lake, in Espanola—to our east, in east Sudbury, collocated with the primary health care centre.

1520

So we've leveraged a lot in the last two years, building on the richness in our mental health team and our addiction team and bringing them together. We've made significant improvements with taking our existing resources. None of this is funded; it's just how we've made the money work smarter. So by taking pockets of funding and putting that funding together in one big envelope, we've been able to add some additional resources to what we offer the community, family support being one thing. Rather than having infrequent family support meetings when you can get it together, we're able to leverage our resources and say, "Every Tuesday night we have family support. It doesn't matter if one person shows up or 21 people show up—every Tuesday night." And it's just scheduled, because you've got larger groups to schedule from. So there's obviously some opportunity there.

What's still needed? What our community's telling us, where the demand is in our community: long, long waiting lists for the treatment of mood disorders. It's one area that has not had an investment. There's been no investment in counselling and treatment; in the treatment of mood and anxiety disorders or bipolar disorders, no investments in over 20 years, save and except the inflationary increases that we've seen in the last couple years—you know, 2% here—across the board.

By not having timely access to the treatment of a mood disorder or an anxiety disorder, we're really doing a disservice to the community. People are falling off the rails at work or at school. They're losing their function, they're losing their family and social relationships, and it's leading to, maybe, chronicity that doesn't have to be there. If we can treat and develop a model and invest in—this is one of the highest-volume groups that we see through our doors. It's what they're looking for, and yet there's been no investment. So I think that's an important gap.

The same with day treatment for addictions: The Every Door Is the Right Door strategy talks about withdrawal management services and it talks about residential services, but there's no mention made whatsoever about outpatient addictions treatment. Not everybody can leave their community and enter a 28-day program in some other community; they've got obligations at home. There has been no increase in addictions treatment in an outpatient capacity, again, in over 20 years. Same story: If you're not well in that regard, it shows in your work, it shows in your school. You fall off the rails, and pretty

soon we have a bigger problem than if you were able to get in and get some counselling, involve your family in that counselling earlier rather than later.

Access to child and adolescent psychiatry: It's been spoken about. I just want to reiterate the point that we've got a huge gap in our community. Lots of the issues that we see are that we're treating the adults and in the back of our minds, we're thinking, "My God, they're parents. Who's treating their kids?" We'd love to be able to say what's happening there, but it is really two siloed systems and we've got no mandate to really go there. So if we want to look at families and the health within families, breaking down that silo between adult and children is really critically important to the health of our future, our children being our future.

As an administrator, the silos within mental health and addictions—we've done a great deal within our organization to work despite the silos, to play both sides of the equation and leverage resources between mental health and addictions, but we're stymied at some things. There are just some things that we cannot do, because there's an addictions fund—it comes in an envelope with a program number—and there's a mental health fund—it comes in an envelope with a program number—and never the two shall cross. So that doesn't really make sense, in light of where the province wants to go with an integrated system. We need to have integrated funding.

Just a story: If you have an addiction and come through our door, if we weren't as creative as we are, we might say to you as you come through the door, "Do you have an addictions issue or do you have a mental health issue? If addictions, line up here, and if mental health, line up there." That's really sort of silly, yet the funding envelopes kind of encourage that to happen and the reporting of data encourages that to happen.

The silo between the Ministry of Health and Long-Term Care and the LHINs, which fund the adult world, and then MCYS—and MCSS. I want to mention MCSS because of the adults with developmental disabilities. Many of them have mental health and addictions issues, and again, they are funded through a separate stream, a separate access point and separate data collection. It just is not working for us, the provider.

Solutions: Eliminate the silos; I think that's very important. We have standard assessments that are done. These standard assessments have different names; they ask the same kinds of questions, and it doesn't make sense that, depending on your answer to the question, "Do you have a mental health issue or an addictions issue?", your information resides in one stream and not both. Because if you scratch at the surface long enough, you'll see that the person with the addiction probably has some underlying mental health issues, and the person with the mental health issue may in fact have some compulsive behaviours around drugs, alcohol or gambling that also need to be addressed.

We need to assess and treat families. We talk about person-centred and family-centred. It just makes no sense to me, as a member living in the community with a

family, that I might go to one agency to deal with my issue, knowing full well it's having an impact on the rest of my family, on my kids. Why wouldn't my kids see the same treatment team? Why wouldn't my kids have the same access to support? Why wouldn't we be treated as a whole? Because I think our objective would be to keep families whole and not keep them apart.

It's really important, if we're going to work on a family-centred approach, that we start thinking about across the lifespan. It doesn't make sense that youth would have to give up their support system the day they turn 18 and completely switch to a new set of providers and have all of that rich information about them lost.

One idea that I have is, we've got no discretion as administrators to use our funds creatively. I'm not suggesting that we are—and I know the focus on accountability certainly is very important, given some of the front-page headlines, but if there could be some discretion with our funding to allow for creative opportunity based on what the community has identified as a priority. Right now, there is no ability for us to submit a budget that has 20% of the funds unallocated. Every dollar has to be allocated, and when you account for how you spent the money, it had better match up or there are questions to ask. Yet that doesn't allow any flexibility to the funder to address the priorities that come up through the year, to address those situations where we know that if we could just work outside the box, we could make a difference in people's lives. So, having some discretion in our operating budgets, while still having accountability, I think, is an important thing to consider.

In summary, our current waiting lists, I truly believe, are confounded by the disproportionate effort that's going into siloed and duplicate assessments. If we could free up people from doing double the work at the front door, it means we could take somebody away from the front door and put them behind the front door to actually deal with treatment and move people along who are waiting for treatment. Taking that into consideration, I think—it's not an ask for more money; it's a way of saying that if you just took something off our plates, I think we could work more efficiently.

The intergenerational effects of mental illness and addiction is again why I think we need to be thinking about family-centred care differently than the way it's organized in the province today.

I hope I haven't exceeded my time.

The Chair (Mr. Kevin Daniel Flynn): No, you haven't. You've left about three minutes, so let's start with Christine or Sylvia.

Mrs. Christine Elliott: This is great. Thank you very much, Maureen. I'm really interested in some of your ideas. I guess we're looking at creative ways, and certainly this siloing in the ministries is something that we've heard about from a number of people, because it forces you into pigeonholing certain things that really are more across the board. Any further suggestions you have on how that can be achieved would be most appreciated.

The idea of the operating budget and having some discretionary funds makes a lot of sense because, of

course, needs change over time and different priorities are identified.

Thank you very much for your innovative ideas.

Ms. Maureen McLelland: You're welcome.

The Chair (Mr. Kevin Daniel Flynn): France?

M^{me} France Gélinas: Nice to see you. We've heard from another presenter, who had been very frustrated at using the DART database, the request to have them separated, as in mental health, mental health and addiction, and addiction only. But then we've heard from a number of presenters who really look at integration, where mental health and addiction would always be linked together. You'd get the services you need, no matter what they are. Are those two ideas compatible or not?

Ms. Maureen McLelland: You know, I don't have a particular opinion about which database is better, and I wouldn't want to express which I think is better. I think we have to pick one, and whichever one we go with, it needs to be optimized to still get into the details around—if it's more towards mental health that I'm coming, or more towards addiction, there has to be some ability to optimize that database.

There are thousands and thousands and thousands of person-hours per year, just in my agency alone, going into the data entry to these databases and the reporting from the databases, yet the data sets don't link up.

As an administrator, it's really an exercise in futility for me to know, who are we serving, what are their needs, is this person the same as that person, were they

entered here and entered there? It just doesn't make sense from a planning or from a service delivery perspective. I think we just need to have one, and that one should follow us through our lifespan so that the day I turn 18, my information isn't lost.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Maureen. Is there one more question? Liz?

Mrs. Liz Sandals: Mine actually isn't a question, but I'd just like to comment that with everything we've heard here today, I would really like to congratulate all the people who are working in your cluster of services. In all the travelling that we've done around, this is the best example of service integration and really having your act together so that you're concentrating on how to deliver service rather than silos. We totally hear what you're saying about children and all these silly boundaries.

Ms. Maureen McLelland: God bless you.

Laughter.

Ms. Maureen McLelland: Thank you very much. It has been a lot of work on everybody's part. We're working rather well as a team.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Maureen. Thank you very much for coming today. That was a great presentation.

Ms. Maureen McLelland: Safe ride back.

The Chair (Mr. Kevin Daniel Flynn): Thank you. We're adjourned now to Thunder Bay. The bus leaves for the airport at 3:45.

The committee adjourned at 1531.

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Select Committee on Mental Health and Addictions

Mental Health
and Addictions Strategy

Comité spécial de la santé mentale et des dépendances

Stratégie sur la santé mentale et
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SELECT COMMITTEE ON
MENTAL HEALTH AND ADDICTIONSCOMITÉ SPÉCIAL DE LA SANTÉ
MENTALE ET DES DÉPENDANCES

Friday 11 September 2009

Vendredi 11 septembre 2009

The committee met at 0904 in the Valhalla Inn, Thunder Bay.

MENTAL HEALTH
AND ADDICTIONS STRATEGY
CANADIAN MENTAL HEALTH
ASSOCIATION, THUNDER BAY

The Chair (Mr. Kevin Daniel Flynn): Okay, ladies and gentlemen, if we can call to order for this morning, the fourth meeting this week of the Select Committee on Mental Health and Addictions. Our first delegation is Maurice Fortin, Canadian Mental Health Association, Thunder Bay. Maurice, if you'd like to come forward.

Mr. Maurice Fortin: Here is all right?

The Chair (Mr. Kevin Daniel Flynn): Any one of those chairs you like, any one you're most comfortable at. There are some clean glasses and water there.

Mr. Maurice Fortin: There's a light on, so I assume it's the right one.

The Chair (Mr. Kevin Daniel Flynn): They'll control that for you.

Everybody today is getting 20 minutes to make their presentation. You can use that any way you see fit. If you could leave a little bit of time at the end, we find that works as well, but it's entirely up to you. It's all yours.

Mr. Maurice Fortin: All right. Good morning. Since I'm the first, I want to welcome you to Thunder Bay. We're certainly pleased to have you here. We know you've been in several communities thus far, and we're sort of on the tail end of all that, so welcome.

I'm going to read it mostly, but I'll divert from it slightly. First of all, I want to say thank you for being here. We appreciate the opportunity to talk about the mental health and addiction struggles of people in Thunder Bay and the surrounding region. We also applaud you for your goals in terms of trying to determine the needs of children, youth and adults and to hear about innovation in community services.

The CMHA is one of the oldest voluntary associations in Canada. We've been around since 1918. I represent the Canadian Mental Health Association, Thunder Bay branch, one of 33 branches in Ontario. We're a national federation of organizations, which means each of us is separately incorporated and governed by a local board of trustees. Our 15-member board of directors represents a broad spectrum of our community in terms of where they

come from and in terms of their employment. Many, many of them have had a lived experience of mental health or a family member's.

The other thing I want to tell you is that we are truly a community-based organization. We focus on one business only: the delivery of services to support people with mental illness and addictions issues, to support them in recovering and living fulfilling lives in the community. We're all about helping people stay in their community and recover from mental illness.

I thought it would be useful today to try to paint a bit of a picture of who our programs serve. I think it's important for you to understand and have some sense of who our clients are and what their socio-economic struggles are. Some of the information I've taken is research-based, from the Matryoshka study, which is part of a larger provincial study that our organization was a partner in with the Centre for Addiction and Mental Health, specifically two programs: our court support services and our early intervention services. I've also solicited some input from our own services. I've gone and spoken to our directors and front-line staff in our case management programs in our crisis services. I thought it was important for you to understand what we're seeing on the ground.

Let me tell you a little bit about our clients. Our court support program reports that 23% of our clients are diagnosed with mood disorders, 15% with schizophrenia and 15% with personality disorders. In terms of substance abuse, 50% of our clients report that they struggle with drug and alcohol issues. Our staff, on the other hand, estimate that that number's probably closer to 80%.

Our crisis response service sees many people in situational distress. In this community, we're the provider of the crisis response services for the city of Thunder Bay and for the Thunder Bay district. Many of our clients presenting in that program have mood or personality disorders, and the majority of those clients struggle with substance abuse issues. Many, many of our clients have been the victims of physical, sexual and psychological abuse.

Within our early intervention service, 50% of clients have a schizophrenia-related disorder. Many people identified as having a mental illness may suffer from a brain injury or have been misdiagnosed with fetal alcohol syndrome, which we simply don't know enough about and tend to often misdiagnose. Often they suffer from co-

occurring issues, so they may have a brain injury but they also suffer from depression, or they may have a co-occurring major diagnosis of mental illness like schizophrenia. They often present with complex challenges that are difficult to assess and treat.

0910

Furthermore, these people also struggle with a number of important socio-economic challenges. For example, within the court program, 85% of our clients live on ODSP or general welfare assistance, and they report an average monthly income of \$677. I want to say that again: a monthly income of \$677. Obviously, they exist well below the poverty line. Across all of our programs, most clients have received ODSP. For the services that we provide, both clinical services and rehabilitation services, we are serving people who have a diagnosis of a major mental illness; we're certainly not serving the "worried well" and we're not serving those who are doing okay in community but need counselling services.

The wave 2 results of the court study show that 85% of our clients have not completed high school. Across all of our programs, most clients have not had an opportunity to attend college or university or to acquire a trade. In most cases—82% in the case of the court program—the lack of opportunity stems from the interruption of their education because of the onset or recurrence of mental illness.

Many of our clients across all programs have other accompanying health concerns such as diabetes or cardiovascular illnesses. Some of them also struggle with issues of obesity, which often stems from the long-term taking of psychotropic medications. In addition, most of our clients have limited or no access to very important dietary and other supplements needed to manage these other illnesses.

They also have poor access to psychiatric and primary care services. As a result, ongoing and emerging health issues go untreated or only become treated when they reach an acute phase. I've often heard it said that our clients live an average lifespan of 25 years less than the normal population. I also want you to know that mental illness and addictions kill. This year alone, my staff or myself have attended the funeral of a long-time consumer-survivor who had a heart attack in his mid-50s; we also attended the funeral of a wonderful young man who was a volunteer for CMHA and who committed suicide. He had long-time struggles with depression. Mental health and addictions issues kill. People die.

What do people struggling with these issues need? Certainly, they need housing. In preparing for this presentation, I spoke to some of our front-line staff. The need for housing arose immediately. As one housing worker stated, "We need safe, affordable housing, and lots of it." They went on to talk about the need for a continuum of housing. We need specialized transitional housing with high levels of support to ensure that people with complex needs, such as people who have co-morbid issues like fetal alcohol syndrome and other mental illnesses, have the level of support they need at that time.

Housing strategies often need to ensure that the less desirable folks, such as the long-term homeless or people who are struggling with addictions issues, are properly served. In some cases, that means on-site support. Many can benefit from safe, decent, affordable housing supported by case managers.

In Thunder Bay, access to housing is a real problem. The wait list for accessible housing and the wait list for single housing is months, if not years, away. Many of our folks are single folks. They don't have families, so there is a need.

The issue of decent, safe, affordable housing is such an issue. You simply cannot move on with your therapy, with vocational issues or with any other kinds of issues if you're worried about the safety and security of the place that you live in or you're worried about trying to simply find a place to live.

Case management continues to be an effective strategy to support persons with mental health and addiction issues. Many of our clients don't have families, and so case managers are really the key person in terms of helping them navigate through the health and social services maze and also key in terms of providing them with ongoing support. We absolutely need more specialized services. We need to improve access to primary care, and I've talked at length about the struggles that our clients have in terms of access to primary care.

Some of the strategies that are working: We know that a couple of CMHAs have had funding to hire nurse practitioners. It's a strategy that makes sense. Certainly partnerships with nurse practitioner clinics and community and mental health clinics also hold great promise.

In this community—because you want to hear about some innovation—we have a partnership with a hospital and another community organization called GAPPs. What we're doing is we're going out into non-traditional places and outreaching to individuals that have complex mental health and addiction issues and trying to engage with them and trying to pull them into accessing services. The services that we're providing are everything from psychiatry to nursing and nurse practitioner care to deal with their primary care needs. While it is early days, we're seeing very good success in terms of helping to redirect these folks away from emergency departments, but we continue to have struggles in terms of accessing the kinds of service and the intensity of service that people need.

Anyone with a history of conflict with the law or someone who's had charges or convictions of serious crimes such as robbery or assault is often denied access in the mainstream services. Many of the folks have been labelled difficult, and folks who have a diagnosis of a personality disorder who are often resistant to care or treatment continue to have great difficulty in accessing service. Services for persons with complex needs that are hard to serve, that are specialized and that are targeted for their particular issues are absolutely important. We need to develop assertive community treatment teams and intensive case management teams that are actually

targeted for this population. It's the only way that we're going to deal adequately, and they need to be adequately funded because we need to ensure that the community's safe, that my staff are safe and that the clients are safe.

Once people are adequately housed and they receive the treatment and therapy that they need, then they can move on to try and resolve some of their issues in terms of vocation, education etc.

I want you to know that community mental health programs are working. We know from the study that our early intervention programs are demonstrating fewer hospital admissions and fewer emergency department visits. Our own crisis response program is being successful in diverting people from unnecessary hospital emergency visits. Only 10% of the clients that we see do we end up escorting to hospital to be considered for admission, because we're doing a very good job of finding community solutions. We know that case management works as well, and they're reducing hospitalization rates, especially case management when accompanied by decent affordable housing.

But we need adequate funding. Our crisis residential program in this community is only funded four days a week. You'd better not have a crisis and need crisis housing on the weekend because we can't provide you with service.

We know the select committee has already heard from the Auditor General of Ontario, and the 2008 audit of the community mental health sector speaks to the issue of high rates of unmet need, the shortage of supportive housing and the continued need to increase funding for community services. We've read the report; we think they got it right. We hope you're listening and reading that report as well.

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I want to thank you today for the opportunity to speak. We absolutely applaud you for being an all-party committee of the Legislature, because mental health and addictions is not a partisan issue. It's an important issue. We look forward to hearing your long-term strategy in 2010 and we want to let you know that we're committed to ensuring that together we want Ontario to become a leader in mental health and addictions care.

The Acting Chair (Mrs. Christine Elliott): Wonderful. Thank you very much, Mr. Fortin, for your presentation. We do have a few minutes left for comments, about four minutes, so I'd invite other members of the committee to ask any questions, starting with Sylvia Jones.

Ms. Sylvia Jones: Thank you for coming today. I had one quick question and then one more in depth.

Are you utilizing peer support workers in your programs?

Mr. Maurice Fortin: We are not at this point utilizing peer support programs.

Ms. Sylvia Jones: My second question was related to the partnership you referenced called GAPPS. The hospital was one of the—

Mr. Maurice Fortin: St. Joseph's Care Group, which was the receiving hospital for the former Lakehead Psychiatric Hospital, and another community organization called Alpha Court.

Ms. Sylvia Jones: When you say that you are doing outreach in non-traditional places, can you expand on that?

Mr. Maurice Fortin: We are going to places where street people are engaged, so we're going to some of the more difficult street areas where people are. We go to riverbanks, we go to any of the malls where they may hang out or the coffee shops. The two workers we have—one of them was a needle exchange worker and so he absolutely knows where those folks who are disengaged from the system are, and that's where we're connecting with them. Shelters is another example.

Ms. Sylvia Jones: Thank you.

The Acting Chair (Mrs. Christine Elliott): Maria Van Bommel has a question as well.

Mrs. Maria Van Bommel: You mentioned in your presentation that case management is critical because so many don't have families to help support them through their illness. We've been hearing repeatedly as well from families that are frustrated with the privacy regulations and laws that keep them from being as involved in the treatment and therapies as they would like to be. Do you have that similar encounter with the families?

Mr. Maurice Fortin: In some cases we absolutely do and we appreciate the struggle that families have in terms of trying to find out and be part of the care, and some of those are confidentiality issues or restrictions. But we have also some innovation—early psychosis programs, for instance. As soon as the client walks through the door, they also engage with the family simultaneously. So we're providing support and education to the family at the beginning of the process. Those are some very good models in terms of taking a different approach to making sure that the needs of families are met. But it is an issue across many programs.

Mrs. Maria Van Bommel: So the program you're suggesting basically is to bring the family in early. Do you find that works well or do you find, especially in some cases where the client's psychosis becomes increasingly worse, that they try to exclude their family, that there's a paranoia about what the family's intentions are for their treatment?

Mr. Maurice Fortin: That does happen on occasion. We discourage it with the client. We try to educate them. But in the early psychosis program, most of the folks we see are between the ages of 14 and 20, and so they tend to have a better relationship with their families. We're also treating people early in the onset of their illness and so many of those issues are not there yet, in terms of those difficulties. We're trying to negate them, really, by serving the client but serving the family at the same time. That program, sadly, is only one good example of a good approach to working with families.

Mrs. Maria Van Bommel: So are you finding that by earlier intervention and bringing the families in earlier,

there is less likelihood of this kind of alienation coming later on?

Mr. Maurice Fortin: Yes, that has been our experience. Obviously our families are the best folks to ask that question, but it's our observation that it certainly enhances the relationship that's going on.

We're also doing, in another program that we fund-raise for, some very good work. We run a family recovery series. What we're doing in that program is that we're actually trying to help family members understand how to support their family member in recovery, and we're using very positive approaches and language. So really what we're trying to do is instill the family members with some sense of hope and that people can have fulfilling lives. Our philosophy within our organization is all about helping people recover to the best that they can from their mental illness and to live healthy and productive lives in the community. It's all about returning people to active community life.

Mrs. Maria Van Bommel: Thank you.

The Acting Chair (Mrs. Christine Elliott): Thank you very much for your presentation today. It's most helpful and we appreciate it.

ALZHEIMER SOCIETY OF THUNDER BAY

The Acting Chair (Mrs. Christine Elliott): Our next presentation is from the Alzheimer Society of Thunder Bay. Jennifer Fawcett and Dr. George Morrison, please come forward, sit where you'd like and make yourselves comfortable.

As you've probably heard, you have 20 minutes for your presentation and you can use the time in any way you'd like. If you want to leave some time for questions at the end, that's fine. Start whenever you're ready.

Ms. Jennifer Fawcett: Thank you. Good morning, Madam Chair, members of the select committee and ladies and gentlemen. My name is Jennifer Fawcett, and with me today is Dr. George Morrison. We are here to present today on behalf of the Alzheimer Society of Thunder Bay.

I am the Alzheimer Society's First Link coordinator, and Dr. George Morrison is the lead physician in the 25-bed dementia care unit of the Lakewood Psychiatric Hospital under St. Joseph's Care Group. Dr. Morrison is also a past board member for the Alzheimer Society of Thunder Bay and a very dedicated volunteer. Dr. Morrison works directly with patients with responsive behaviours, from a non-pharmacological and pharmacological approach, who are in hospital. In my role, however, as the First Link coordinator, I liaise with health care professionals in primary care to promote early intervention immediately following a dementia diagnosis. I also work with professionals in acute and chronic care to enable support for families at every point in the disease continuum. We wish to begin by thanking you for providing us with an opportunity to address you this morning.

There are 39 Alzheimer chapters across Ontario, reaching across all 14 local health integration networks. I

believe you've heard from a few others in some of the earlier presentations. In all chapters, services and supports are in place to assist people with dementia and their partners in care throughout the entire continuum of the disease. However, in 23 chapters, a program called First Link helps connect people diagnosed with Alzheimer's or a related dementia to their local Alzheimer Society services and other community resources as early in the disease process as possible.

First Link has been shown to be particularly successful in providing early-stage support. This program provides physicians and other health professionals with a direct referral mechanism for their patients after diagnosis, at which point the Alzheimer Society introduces the person with dementia and their family to education about the disease in a timely manner which is best suited to the learning requirements of people with dementia and older adults; with ongoing counselling support; opportunities for peer support; and linkages to other supports and services when and as required. First Link is a program that has been designed to meet the needs both of people with dementia and their partners in care in the health care system. By providing people with education and support across the entire disease process, people are less likely to reach the system in crisis. People are more adequately prepared to make decisions about home care interventions, advance care planning, their entry to long-term care, should that present itself, and other difficult decisions that are oftentimes inevitable.

The Alzheimer Society of Thunder Bay serves the community and the district of Thunder Bay, which as you know is a large geographic area. The district includes 27 communities within almost 104,000 square kilometres. We have been in operation since 1986, and in accordance with all Alzheimer Society chapters across the province, our mission is to alleviate the personal and social consequences of Alzheimer's disease and related dementias and to promote research. We have a staff of nine, including a number of social workers, making up our clinical team.

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In recent years, the need for our programs and services has dramatically increased. In fact, this past year we have seen an increase to the extent that we have approximately 20 new clients per month coming through our doors looking for education and support through the new First Link program. This is not altogether surprising, as the latest statistics indicate that in Canada, one in 11 people over the age of 65 and one in three over the age of 85 have Alzheimer's disease or a related dementia. We believe that in Ontario there are over 160,000 cases, and it is expected that that will rise to nearly 170,000 cases next year alone, in 2010, and to 350,000 in 2031. Currently there are an estimated 3,150 people living with dementia in northwestern Ontario.

These are sobering numbers indeed, particularly when you think of the Alzheimer chapter providing services across the region for that number of people. In fact, within a generation, it is expected that the number of

Canadians with Alzheimer's disease or a related dementia will more than double, ranging between one million and 1.3 million people in Canada. That number is from a recent study, released in 2009, called the Rising Tide. In short, dementia is the most pressing mental health issue facing our seniors. As a result of the ongoing care requirements for people with dementia, mental health issues related to caregiver stress and burnout are also on the rise.

We are here today to ask you to consider the needs of people with dementia and their partners in care as you move forward with recommendations for a comprehensive Ontario mental health and addictions strategy. Specifically, we wish to draw your attention to the needs of people who have been newly diagnosed with Alzheimer's disease or a related dementia. These people are considered to be in the early stage. A diagnosis of Alzheimer's disease or a related dementia, as you can well imagine, brings a great deal of fear and anxiety for both the person receiving the diagnosis and their family, who will care for them.

Not unlike those with other mental health issues, people with dementia are often confronted with the stigma associated with Alzheimer's disease. Unfortunately this can not only prevent people from getting a diagnosis but also from reaching out for help. Most people are aware that there is no cure for Alzheimer's disease. However, few people know that there is treatment, with a history of success and support, and enabling people to stay at home and aging at place for as long as possible. Therefore we believe that often a person who suspects dementia, has some of the warning signs or has just received a diagnosis, may be inclined to ignore symptoms or signs for as long as possible or until a crisis occurs, at which point it is more likely that that person with dementia and their partners in care will enter our system without adequate preparation or warning.

Hence, in many of our communities we continue to face growing pressure on emergency departments, alternate-level-of-care beds and early admissions to long-term care. A 2009 report from the Canadian Institute for Health Information shows that dementia accounted for almost a quarter of alternate-level-of-care hospitalizations and more than a third of alternate-level-of-care days in 2007-08.

Another recent study, entitled *The Burden of Neurological Diseases, Disorders and Injuries in Canada*, identified Alzheimer's disease and related dementias as having the second-highest impact on health care costs among all neurological diseases, second only to strokes. Therefore there has been in the past number of years increased recognition that primary care has an early role to play in meeting the needs of people with dementia.

As indicated earlier, the Rising Tide study, released just this year, suggested that in the next decade we are likely to see a sharp rise in the number of people with dementia. We recognize that as a result, new and creative measures which incorporate inter-professional care and community collaboration will provide some of the best solutions for the provision of care.

We would like to suggest that the select committee consider potential solutions to meet the needs of people with early-stage dementia specifically as you consider the mental health and addiction needs of Ontario's seniors. As much of the current research suggests and some of our early findings reflect, people with dementia and their partners in care typically manage their disease much better when there is an early intervention after diagnosis. When access to ongoing, reliable support and education is provided in the early stages, serving to inform and support families throughout the continuum of the disease, crisis is often mitigated and prevented, and caregiver burnout and illness are avoided.

Since launching First Link in Thunder Bay in February 2009, we are seeing an increase in referrals and expect this number to continue climbing, and we will likely face a capacity issue in delivering our services, which are currently provided free of charge and without restrictions or caps of any sort to the consumers.

One of our greatest challenges with the First Link program is having the human and other resources to deliver this program within our vast geographic territory with a diverse population, including First Nations people. To this end, as a small non-profit society, we are embarking on evaluating telehealth services and community capacity-building projects, which, as you can understand, are often challenging for a non-profit agency to sustain due to fiscal restraints and our reliance on private and public support.

Over the past decade, with the divestment of some services formerly provided within psychiatric hospitals to a more community-based approach, there has been somewhat of a cultural shift in health care. We believe that, as part of this cultural shift, programs like First Link have strengthened the delivery of health care support. We believe that continued and expanded investment into services and supports for people with Alzheimer's disease or a related dementia may prepare us well for the rising tide that the Alzheimer Society of Canada study speaks to. That, most importantly, will provide the greatest potential to maximize quality of life for persons with dementia and to support these individuals and their families, while reducing institutionalization and overall health care costs.

In conclusion, we would urge the select committee to include in your report a specific recommendation to government to include support for people with early-stage Alzheimer's and related dementias.

Thank you, Mr. Chairman, members of the select committee, ladies and gentlemen. Dr. Morrison and I would now be very happy to take any questions you might have.

The Acting Chair (Mrs. Christine Elliott): Thank you very much. We do have some time for questions, starting on this side, if there are any questions. Yes, Ms. Sandals?

Mrs. Liz Sandals: Your name is the Alzheimer Society of Thunder Bay, but I take it from your com-

ments that you serve all of northwestern Ontario. What area are you serving?

Ms. Jennifer Fawcett: Our catchment area: There are two Alzheimer chapters in northwestern Ontario—the other is based in Kenora. They serve the Rainy River district and we serve the Thunder Bay district, so basically from Atikokan to essentially Longlac in the east. It's not the entire service. They don't currently have a First Link program in Kenora.

Mrs. Liz Sandals: So you would have difficulty, then, serving people in the smaller communities that aren't actually right in Thunder Bay?

Ms. Jennifer Fawcett: It's very challenging. We did a tour this spring where we went out to the smaller communities that are in our catchment area. We are confronted with caregivers who often are female—women who have never driven in their life—and their spouse is soon to be institutionalized and they are struggling to keep them at home as long as possible with very little support, very minimal support.

One of our projects is to do sort of a community capacity-building type of exercise, where we pilot a small community and we try to empower them to have support groups left behind that we can visit periodically and enable some community champions to come forward with a special interest in seniors' mental health and have them run support groups. We link quite strongly with the community care access centre in those communities and do work back and forth to enable those services.

Mrs. Liz Sandals: Okay. That was my next question, how you link with the CCAC, but you've got that link in place.

Ms. Jennifer Fawcett: Yes.

Mrs. Liz Sandals: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Maria?

Mrs. Maria Van Bommel: We're just getting back into things here.

Further to Liz's question about your catchment, so to speak, I'm just wondering, how do you work or interact with the aboriginal population in the north?

Ms. Jennifer Fawcett: That's another growing area for us. We have visited some of the First Nations communities. One of the things we are finding is that there is not the recognition that Alzheimer's disease is a concern within the community itself. It certainly exists. It's beginning to be recognized. I think, because it is somewhat of a younger population, they're not as confronted with the disease. I also believe it's somewhat accepted as a natural part of the life and death cycle, so it may not be seen as behaviour that might be out of the ordinary, but certainly they're coping with it by keeping people at home, again, as part of the culture for the home-based care.

We believe we have a strong role in providing education to caregivers on how to best enable to keep people at home and how to recognize the signs of dementia, that it isn't a normal part of aging, and that there are supports and treatment available. So it's an education process.

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We're in the process, this fall, of holding a number of meetings with aboriginal organizations in Thunder Bay on how we can do a better job of supporting. But some of it boils down to whether we have the capacity on the staff to deliver culturally sensitive programming, and that's certainly a concern for us and one of the areas that we'd be looking to invest in hiring the right people to do that. So that's certainly a gap.

Mrs. Maria Van Bommel: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Christine or Sylvia?

Ms. Sylvia Jones: Just one question about First Link. That's all coming through the LHIN?

Ms. Jennifer Fawcett: Yes, our funding is through the aging at home strategy.

The Chair (Mr. Kevin Daniel Flynn): Are there any other questions? If not, I'd like to thank you for coming. I wasn't here for your presentation, but I bet it was a good one.

ANDREAS BUCHHOLZ

The Chair (Mr. Kevin Daniel Flynn): Our next presenter this morning is at 9:40, Andreas Buchholz.

Okay, it's all yours. Everybody gets 20 minutes this morning and you can use that any way you see fit. If you would leave some time at the end for some questions, that would be great. It's all yours.

Mr. Andreas Buchholz: All right. First of all, I'd like to thank you all very much for coming to Thunder Bay and giving us this opportunity to talk to you today about our concerns on the mental health system and considering our suggestions. My name is Andreas Buchholz, and I'm a volunteer with the Schizophrenia Society of Ontario. I also sit on the board of the Schizophrenia Society of Ontario, but I'm not speaking as a board member.

My purpose here today is to advocate for people who have a mental illness or a mental condition that is poorly treated or untreatable and have come in contact with or are destined to come in contact with the criminal justice system. To me, it doesn't make sense to charge people with a criminal offence whose thinking ability has been compromised by the effects of a serious mental illness. Sometimes even after a person's mental illness has been stabilized, the resulting cognitive function has been reduced to a point where they cannot make important judgmental decisions. These people should be also diverted from the criminal justice system.

Do we expect a person who has just broken a leg to get up and walk normally at that moment? No. Do we expect a person who has diabetes to have a pancreas that properly assimilates sugar? No. Then why do we expect a person whose brain is diseased to still be able to continuously make decisions that would keep themselves within the boundaries of the law?

What we need is a system that will divert people that have a poorly treated or untreatable mental illness from the criminal justice system so that they can get proper

treatment for their illness. Although there are systems in place to do that, they only apply to certain charges and are not available across the province; and for charges that are more severe, like assault, and where they do not meet the criteria of "not criminally responsible," they often end up in jail without treatment. The system needs to ensure that all mentally ill people receive the treatment they deserve regardless of the charges that are brought against them.

There was a study recently done in Edmonton—you can Google it; it was written up in the *Edmonton Journal* in July—to answer the question of whether treating mentally ill offenders for their illness would reduce the incidence of reoffending. They took a group of mentally ill offenders who were in trouble with the law over an 18-month period before the study began and arranged treatment for their mental illnesses, and provided them shelter and meaningful work. The result was that over the next 18 months following the treatment, 80% of this group did not reoffend. That leaves 20% that still reoffend, and in my opinion, a percentage of these reoffend because of the following reasons:

- (1) They have an untreatable mental illness.
- (2) Their mental illness was not effectively treated.
- (3) They have other mental illnesses that have not been diagnosed alongside their treated mental illness. and
- (4) Their mental illness has been effectively treated, but they are left with a reduced cognitive function caused by their mental illness.

So what do you do with people who commit crimes that are based on a poorly treated mental illness or condition? If these people were never sick, would they still commit these crimes? I would say, for the vast majority of them, no. The incidence of criminal behaviour, then, would be the same for the general healthy population. So in reality, they deserve the same quality of life as any healthy individual with some provisions to protect them from themselves and society. The problem is we presently do not have health facilities that can accommodate people who behave contrary to the laws of our society because of their mental illness.

My experience: I have a brother who is a couple of years younger than I am and has a serious mental illness; perhaps he has multiple mental illnesses. He was diagnosed with schizophrenia and is taking the last-resort medication, clozapine, to stabilize him. Although he is stable, he still hears voices and cannot distinguish reality from fantasy. He has been institutionalized for 30 years. Many attempts to integrate him back to society have failed.

One of his anti-social behaviours is that he tends to strike out with his fists at people without provocation. This behaviour tends to get assault charges pressed against him periodically from fellow patients and staff at the local institution. Everything attempted so far to prevent my brother from striking those around him has not been successful, except for one. This method involved having a member of the staff accompany him continuously through his waking hours. But he has to be

monitored continuously. There was one occasion when a staff member assigned to him turned her back briefly and my brother immediately struck a fellow resident.

Over the years, my brother has had several charges pressed against him, and currently there are three more. Even though they have him in voluntary restraints to limit the extent of his arms, he is still able to harm somebody. His frequency of attacks has increased over the years. Ten years ago, there were two or three incidents a year. Over the last few years, it has ramped up to the point where there is now an incident every two weeks.

These are the emotions that my family and I have to live with:

Anguish: Each incident further reduces the options he has available to him. We fear that he will go to jail, we fear that he will have to leave our community for a long period of time, and we fear that with each assault, he may come closer to someone who could seriously injure my brother or worse. We fear that if he goes to jail, he will be a target of other inmates because of his mannerisms and nonsensical way of talking.

Frustration: Why can't his behaviours be stopped? Why can't he be in an environment that will protect those around him and give him a good quality of life until they find a solution to his behaviour? Why is he allowed to walk around other people without being closely supervised when everybody knows full well that he will strike out again? I know this costs money, but what about the emotional costs of his victims and families? Locking him up is no solution either. This would dramatically reduce his quality of life and would worsen his symptoms. Every incident increases the anguish and frustration we are feeling. We are very anxious and fearful about my brother's future.

The patients there have their own issues to deal with, and we are very concerned about the people who live with and work around him. They don't need to live in fear of someone who strikes out at them at random. We also feel very much for their families—some of their relatives are quite old—because they have this additional burden of worry for the safety of their loved ones.

Anger: We also feel anger at the mental health system, because they are unable to do more to help him because of limited resources and exceedingly difficult access to available resources. They have never dealt with a patient like him, even though they've known and cared for him for 30 years. Shamefully, we also feel anger toward my brother for his continuous acts of aggression, even though we know he may not have any control over them.

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Legal fees: We have been hiring the best lawyers we can afford to represent my brother. This has cost us thousands of dollars, and now he has three more charges against him: all unnecessary had he been prevented from getting himself into these situations using strict supervision. These incidents have caused us great heartache, frustration, anger and thousands of dollars in legal fees, and it doesn't seem to end. In fact, it's getting worse.

One-on-one supervision of individuals like my brother will cost a lot of money, but putting these people in jail

or in some form of isolation because of something that is no fault of their own is no solution either, not to mention legal costs, court costs, costs involved with the actions of the individual, police costs, emotional costs to victims and family members of the victims and also the emotional costs to the mentally ill person. For those who re-offend because of a poorly treated or untreatable mental illness or condition, there needs to be a community-based environment that is safe for the individual and safe for the community. At the same time, it must give them a quality of life that is as close as possible to the average person who is healthy.

The best place to keep the mentally ill reoffender is in their home community close to their families, instead of shipping them out to designated facilities in other communities. But community-based facilities are just not equipped to deal with mentally ill reoffenders, particularly those who are violent. I have a friend who lives in Kenora, Ontario, who has a severe form of depression and is possibly also bipolar. In one particularly bad incident he was having, he checked himself into the hospital there. There, they encouraged him to be open about his thoughts and feelings so that they could properly diagnose and treat him. He thought, "Okay, great." So he told his doctor that he was having violent thoughts toward people. The doctor told him that he'd better keep those thoughts to himself. If he mentioned that to the staff, they would bring in large staff members to restrain him and call the police, as the hospital is not equipped to manage patients who are violent: "If you are violent toward yourself, we can deal with that, but not toward other people."

Care facilities need to be equipped to manage violent patients too. Jails are not psychiatric hospitals. How can patients be honest about their symptoms and receive the care they need and deserve?

What are the solutions? Here are my solutions to keeping the mentally ill charged with offences from the criminal justice system and providing them with the best quality of life:

- (1) Instead of charging the mentally ill with offences, treat them for their mental illness.
- (2) Equip all care facilities with means to manage violent patients.
- (3) Assist them with housing if they require it.
- (4) Assist them with keeping to their medication schedule.
- (5) Assist them to discover and pursue their interests.
- (6) Assist them in establishing meaningful work.
- (7) Assist them in establishing a social network.

For those whose mental illness or condition is such that it cannot be effectively treated and who are at a high risk to reoffend, then I propose the following:

- (1) Provide supervision to ensure the safety of the individual and society. Some require little supervision; some, like my brother, would require constant, one-on-one supervision. This, of course, would be extremely costly, but there also would be cost savings from the

actions of the mentally ill offender: court and legal costs and the emotional costs of the victims.

- (2) Have the option of using restraints if the person is unpredictably violent.

- (3) Maintain a quality of life as close as possible to the average healthy person. This includes social interaction, daily activities like hobbies and exercise, meaningful work, etc.

Conclusion: People who commit crimes because of the effects of their mental illness or mental condition have every right to be treated for their illness instead of having to go through the criminal justice system, regardless of the crimes they commit. The Edmonton studies show that had they been healthy, they most likely would not have made the same decision. Ideally, society will evolve to the point where mental illness can be recognized, diagnosed and treated before the individual begins to commit crimes.

Community care facilities need to be equipped to care for individuals who are violent, so that they can get the care they deserve. People who have mental illnesses and conditions that are poorly treated or untreatable still deserve a quality of life, just like everybody else.

Thanks very much for listening.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Andreas. Great presentation. You've left about six minutes for questions. Christine? Sylvia?

Mrs. Christine Elliott: I have one factual question. First of all, thank you very much for coming. I think you've highlighted some of the really significant issues that we need to deal with. There's no question that for many people with a mental illness, putting them through the criminal justice system is not the answer, so we're taking your comments very seriously.

I'm just wondering where your brother is now. Without naming where he's living, is he in a hospital setting, in a secure facility in hospital?

Mr. Andreas Buchholz: Yes.

Mrs. Christine Elliott: Okay. I'm sorry that that's necessary, but we are taking your considerations very seriously, because there is a significant gap there that we need to address. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Other questions?

You must have done a wonderful job explaining everything. Thank you very much for coming.

SANDRA MacLEAN

The Chair (Mr. Kevin Daniel Flynn): Our next speaker this morning—we've all been looking forward to this one—is Sandra MacLean. We've heard a lot about it. We knew it would be a little different. Come and make yourself comfortable.

Ms. Sandra MacLean: I'm leaning on the hockey stick, and I figure nobody can go uncheered with a hockey stick.

The Chair (Mr. Kevin Daniel Flynn): That's right. There are some clean glasses and some fresh water there,

if you need any. Everybody is getting 20 minutes to make their presentation, and you have 20 minutes as well. Use that any way you see fit. If you leave some time at the end for questions, that usually works out pretty well too.

Ms. Sandra MacLean: Thank you. I've got contacts in as well. I'm just trying to see if I can—I have bifocals and I still have a hard time seeing. This is as bright as it gets, eh? All right.

Thank you very much for giving me the opportunity to come today and speak. It's been just wonderful.

Presentation to the Select Committee on Mental Health and Addictions seeking input on mental health and addiction needs in Thunder Bay and northwestern Ontario.

I would like to thank the honourable members of the provincial Legislature for coming and for the opportunity given to me today to tell my story as it relates to the need for psychiatric emergency services both in our community and across the province. As a mental health nurse working on the front lines in our community for the past 12 years, I have witnessed how things have evolved and changed. I hope that after hearing my story, you will be able to come to appreciate the challenges that we face, but also our strengths as a community and service providers as we strive to make things better for the people we care for.

Memories of my past experiences working as a mental health nurse always come back to me when I think of why I still love my job. I remember a couple of years ago, while at a concurrent disorders conference in Vancouver, a woman approached me in the elevator at the hotel. She said, "You don't recognize me, do you?" I shook my head, and she replied, "You saw my son in Thunder Bay, and I just wanted to tell you that he's doing much better." The door to the elevator opened and I got out and smiled all the way back to my room.

The people I see on a daily basis are struggling with so many issues that it would be best to prioritize them. The first is access. Access to services for individuals experiencing a mental health crisis or a mental illness is difficult if you do not have a family physician. A family physician is so important when someone is considering starting an antidepressant or is seeking counselling for mental health issues. I have witnessed people's frustration first-hand after they are told that psychotropic medications would not be prescribed because they do not have a family physician to follow up with their response to the medication.

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Lack of access contributes to people not coming for care, and we on the front lines see that it is usually not until they are acutely ill with a psychiatric illness and come to the attention of police, fire or ambulance that they are brought in for assessment. At this time, we see individuals incapacitated by their symptoms to the point where they require longer hospitalizations because they've been struggling on their own for so long without services.

My next priority is providing a safe and welcoming environment. Safety is something we're always aware of, as sometimes individuals who are acutely ill and struggling with depression, panic and obsessive thoughts find it difficult to get help when front-line services are so noisy and chaotic. We find that these individuals often leave before being assessed because they can't cope with the environment. Our only recourse is to call police and have them brought back for assessment, offering no therapeutic advantage at all. Front-line services have no lock on the door, they can turn no one away and, as a result, people can leave before help is provided.

I've been lucky in my time as a mental health nurse to meet wonderful people who present seeking help. I'm in awe of their gentleness and quiet strength. I find that I often have to apologize for the noisy environment I work in and the lack of privacy. I encourage them to bear with me as we are interrupted and asked to move and make do in an environment that is ill equipped to ensure that confidentiality is maintained.

We try our best but I feel for the individuals I speak with who have thought and thought at length about coming for help. When they finally have the courage to come to tell their stories, their struggles are often overheard by strangers. For a person coping with a mental illness, this only adds to their feelings of alienation and vulnerability.

Timely response when people do access front-line services is my next priority. This is critical. For individuals at risk during withdrawal from substances or suffering from a decompensation in their mental health, prompt intervention is crucial but often not possible as front-line services also manage traumatic injuries coming in the door. One would speculate that if someone presented with cardiac symptoms, they would be connected to a cardiac monitor immediately, or if a physical trauma was endured, a trauma team would be contacted to ensure that the appropriate intervention and treatment was begun. In the case of someone who presents with acute depression, obsessive thoughts, panic and paranoia—their wound, their trauma—they are often left to wait until actually admitted to a mental health unit before interventions are initiated to reduce their distress. Caring and capable nurses who are not trained as mental health nurses are providing care for these individuals, and they often say to me, "There has to be a better way."

It has been said that a crisis is a time of danger and opportunity. For an individual living with a mental illness who also has problems with addictions, a crisis is often the time when they are most motivated to make positive changes in their life. Missing these opportunities because of lack of front-line services such as a medical detox, pre-treatment beds or spaces in treatment programs can have dire outcomes for these individuals as they often go back to an environment filled with drug-using friends or dealers. Extricating themselves might not be so easy the next time.

People who have chronic mental health and addiction needs are often marginalized in our community. They

live on the fringe and associate with other individuals with similar problems. It is estimated that at least 60% of individuals diagnosed with a mental illness also have problems with addiction. For individuals who suffer with co-morbidity, they are often the hardest to find services for as programs are saturated and clinicians are stretched to the max as they cope with larger caseloads and people lining up to get into their programs.

I have spoken with parents who have gone into drug dens to bring their opiate-addicted child in for assessment and I can feel the parents' sorrow and fear as they look to the professional for help. Their child denies that they plan to hurt themselves, and with no medical detox available and only one opiate female bed at detox, I feel as if I have nothing to offer except support. I encourage the parents to bring her back if she becomes worse and meets the grounds for a form 1. They look at me in disbelief: "How much worse can it get?" Their child's foot is swollen from injecting IV drugs. The cellulitis is treated, and their child is then sent back to the environment from which she has come.

The IV drug use in our community, whether it is opiates or cocaine, is crippling the lives of individuals of all ages. Compound this suffering with a mental illness, and you can see how complicated things can get. I can only hope that one day, flexible, responsive and immediate services might be available in our community and other communities with the same issues across Ontario.

Size and geographic location are so important and have an impact on front-line services. Northwestern Ontario is roughly the size of France. Northwestern Ontario is dotted with remote First Nations communities and reserves. Flying out of these communities is often the only way people have to access professional mental health and addiction services. I have spoken with families who have driven in from Kenora, Dryden, Schreiber and Terrace Bay with extremely ill family members either suffering either from decompensation of their mental illness or who are acutely suicidal. We then have a huge responsibility on the front lines to get it right the first time, as these individuals have precious few resources to return to.

Mental illness and addiction issues across the lifespan: Children are special. We try to do our best for them because they have usually come from school referred by a counsellor or teacher who is keenly aware that this child may need help. We feel the pressure because of the long wait lines for children with addiction and developmental problems. We have only one child and adolescent psychiatrist in Thunder Bay. The children I speak with are wonderful, funny, bright and resilient. I'm amazed that these qualities come through even when they are coping with past traumas and have problems with emerging mental illness and addiction.

You might ask, "Where is the hope when it appears that issues affecting individuals of all ages in Thunder Bay are so acute?" My hope is in the individuals themselves and their loved ones who bring them to our attention. Their trust is something that I take very seriously.

I've been honoured and privileged to hear their stories over the past 12 years, and it is their trust I will try to repay by offering my advocacy for the best care that can be provided for them.

Better care for individuals coping with mental health and addiction issues in Thunder Bay and northwestern Ontario could be provided with the creation of an integrated psychiatric emergency service attached to the ER at Thunder Bay Regional Health Sciences Centre. My dream fulfilled would be built on four major initiatives:

—The newly created psychiatric emergency service would be staffed by psychiatrists and mental health nurses, ensuring that recovery from crisis and psychiatric illness begins at the door.

—A safe and secure environment for individuals presenting in crisis would be assured. Confidentiality would be maintained, and stories shared would be respected and honoured.

—The attending psychiatrist and mental health nurses in the psychiatric emergency service would provide initiation of treatment, limited follow-up, and referral to providers in the community. Most of all, it would ensure continuity of care and timely intervention for those individuals not requiring admission.

—The psychiatric emergency service would address the addiction issues of individuals with co-morbid mental illness. Timely intervention and response to those with addiction issues would be addressed with community agencies invited to participate in the discharge planning process from ER.

This is just a start, ladies and gentlemen, but if we don't begin, we will never get finished. The right care for the right person at the right time is waiting, yet to be provided. I believe that an integrated psychiatric emergency service should be the model of care for all of Ontario and not just Thunder Bay.

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I would like to thank the select committee for giving me the opportunity to tell my story. If we have time for questions, that would be great.

The Chair (Mr. Kevin Daniel Flynn): That is great, because we do have time for questions. Thank you very much for your presentation. We'll start with Christine and Sylvia.

Ms. Sylvia Jones: Thank you for your presentation. It was excellent. You referenced the child and adult challenges. Yesterday we heard strong advocacy for removing the artificial line between adults and children. I'm gathering from what you're saying in your presentation that you would support the same thing. Is that right?

Ms. Sandra MacLean: As front-line mental health nurses, we see people of all ages. Children are especially important when we look at mental health and addiction issues, in that if we can initiate treatment at the front line, we can possibly affect mental health and addiction issues sooner and turn those addiction and mental health issues around so that our mental health services aren't taxed when these individuals become adults. They have a better chance for recovery if we address their issues sooner.

Ms. Sylvia Jones: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Bill Mauro?

Mr. Bill Mauro: Ms. MacLean, thank you very much for your presentation. I'm interested in the first point that you raised around access for people with mental health challenges, and specifically around primary care.

As you know, in all of northern Ontario and now broadened out into the entire province and country, and globally, there are significant issues related to access to primary care. In northern Ontario and northwestern Ontario we chronically face that challenge. As a government we've taken several steps to try to increase access, and I think many more people now do have access, but there are still big gaps, especially here in northern Ontario.

One of the pieces we brought in was the creation of family health teams where they roster patients. I guess my question to you, as a practitioner dealing with mental health issues on a daily basis, is, do you find that that model is working and creating access for people with mental health issues or are they being—it has always been difficult for them to get access to primary care. Is this model helping them to get care? Do you find that they're being refused to be rostered by primary care physicians? Or do you even have a sense of how that has evolved?

Ms. Sandra MacLean: Thank you for your question. I can only speak from my own experience, and that's on a daily basis over the last 12 years.

With psychiatric emergency services initiated, where someone can be started on medication immediately when they present in crisis or with symptoms and can be seen by a psychiatrist and mental health nurses who can make recommendations back to a practitioner, whose expertise may not be mental health and addiction, that would support that practitioner. I feel that then would open the gateway for dialogue that they would actually take that patient on, because they realize that the medication has been started by someone who knows, so that they have a sense that they're not operating in isolation, that there's actual support out there for them. I think that continuity of care would be continued, then, right at the front door of front-line services. I think it can only help.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Bill. Helena?

Ms. Helena Jaczek: Thank you so much for your presentation. We've heard in the course of these hearings some really quite heart-wrenching stories from parents who have a teenager child who they're very aware is having terrible mental health issues. They've gone to the family doctor and they've gone to emergency, where in fact the diagnosis is made that the child is mentally ill. They run into issues around confidentiality, where the teen really does not want the health care professionals to share with the parents the issues that are in fact there. The child can be discharged, sometimes very prematurely, certainly, in the views of the parents, and they're expected to pick up the pieces without really having had any input.

Now, realizing that there's a balance between confidentiality rights of the patient versus those of the parents, who are in fact required to continue with care, how do you see this issue? Do you have any solutions related to this balance?

Ms. Sandra MacLean: I guess what I see on a daily basis on the front lines when I see individuals is that they usually present in a mental health crisis, whether that's something that's primarily mental health or something that's also triggered by addiction issues or a combination of both.

Across the lifespan, front-line mental health nurses would be the ones who would interview someone with a mental health and addiction issue if they were a child or adolescent; 80% of the recommendations that we put together for the front-line doctor would be based on collateral information obtained from parents. It's not done in isolation. Recommendations from what we can see as mental health nurses, right at the very beginning, involve 360 degrees. They involve the child, the adolescent, the parents and also getting a picture that the parent and the child are actually on the same page.

When you have mental health nurses able to do those kinds of assessments, you get that comprehensiveness. You get that because risk is so important at that stage. We need to have as much information as we can to make qualified recommendations. That is totally important to us. Again, it speaks for psychiatric emergency services for all ages where mental health nurses are involved in that interview process from the time they present in emergency.

Ms. Helena Jaczek: Thank you.

The Chair (Mr. Kevin Daniel Flynn): I have one question for you. Thank you for the presentation, by the way.

It's interesting how systems evolve. I guess when somebody is going through a crisis, the first thing they think of is, "I'm having an emergency, therefore I should go to emergency." I think any sound analysis would tell you that that would be almost the last environment you would want to be in while you were going through a crisis: You've got people having heart attacks; you've got traffic accident victims; you've got elevated emotions; people are sort of running all over the place; you've got children in pain who are crying. That, to me, seems to be the last place you would want to be when you're dealing with somebody with a crisis. How would you describe the place where they should go? What would the environment be like where somebody should go?

Ms. Sandra MacLean: My dream is actually to have a psychiatric emergency service integrated with and adjacent to ER at Thunder Bay Regional Health Sciences Centre so the kind of busy, chaotic environment that you're describing wouldn't be the one that individuals have to deal with who are struggling with mental health and addiction issues.

If the psychiatric emergency service was adjacent to emergency, you would have treatment beds; you would

have interview rooms; you would have assess-to-admit beds; you might even have a holding bed; you'd have interview rooms where discharge planning could begin right from emergency with community service providers. You'd have a safe environment where people couldn't just run out the door before you had a chance to assess their level of risk; you'd have treatment and intervention begun by mental health nurses and psychiatrists who can begin to talk to individuals and help them reframe the way they're thinking, get to the bottom of their symptoms and start that treatment process right at the door. It's so important and, unfortunately, because of our lack of front-line services at this moment, that is not happening.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today. That beep was telling me that your 20 minutes were up. You've got to tell us about the hockey stick, though.

Ms. Sandra MacLean: One last thing that I have to say—it's a quote, actually. First of all I'd like to thank everybody who has come today to support my story because this is their story as well. These are people who work in emergency, community service providers, head of emergency, mental health nurses, psychiatrists, and they've all come today to support this story because this is theirs as well.

The reason for my hockey stick: In closing, I'd like to quote from a famous Canadian hockey player, number 99, Wayne Gretzky, now turned philosopher. Wayne has said that "you can pretty much guarantee that 100% of the shots not taken will never get in the net."

Ladies and gentlemen, this is our shot.

Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much. An excellent presentation.

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ONTARIO PSYCHIATRIC ASSOCIATION

The Chair (Mr. Kevin Daniel Flynn): That's going to be followed up by the Ontario Psychiatric Association: Dr. Paul Mulzer. Let's see you top that.

Dr. Paul Mulzer: I think it's always problematic when you come with no props.

The Chair (Mr. Kevin Daniel Flynn): That's right. Where's your stick?

Dr. Paul Mulzer: I'm in trouble from the beginning.

Sandra's a wonderful example of the quality of mental health care providers that we actually have on the front line. First, it was just wonderful to hear her speak. She was very worried about her presentation, but clearly she's very articulate and very passionate in her perspective of the emergency needs here in Thunder Bay.

I'm representing our provincial organization, the Ontario Psychiatric Association. It's a great honour to be able to address the group today. I'm very pleased that this is an interministerial group. I think that's really critical. In fact, I think it's one of the most important initiatives: that it really transcends partisan politics and that it's

something that can continue subsequently. I think it's a very important initiative in its own right.

The Ontario Psychiatric Association represents the needs and the services of psychiatrists in the province, both through the OPA, the coalition of psychiatry, and the OMA section on psychiatry. Effectively, with the exception of a small group of renegades, we represent most of psychiatry in Ontario. We're very committed to seeing the growth and development of mental health and addiction services and issues around accessibility that are articulated in the Every Door is the Right Door document. In fact, the issue of comprehensive care delivery is something that we've been very passionate about for over 90 years.

I had the great fortune of attending the summit in July and appreciated having an invitation to attend. I certainly enjoyed dealing with my colleagues there—and of course family members and patients as well, expressing their hopes, really, for another important initiative. Unfortunately, I also have corporate memory, so I've attended many similar things and seen lots of other initiatives that became leather-bound volumes—dusty, wonderful books on shelves going back to, certainly, the Graham report and before. So it would be very important and we're really committed to seeing this not suffer a similar fate, to see it become an initiative that really takes flight.

I note with interest that you describe "transforming" the health care system. I think it's important, the selection of terminology. You're not talking about simply tweaking the system, oiling it, fine-tuning it; you're talking about transforming it. I think that's a powerful statement. It's one that usually comes with a significant financial commitment—

The Chair (Mr. Kevin Daniel Flynn): Just so you don't have to sort of confine your statements, the report was authored by the ministry and by the minister. We're a select committee of the Legislative Assembly, so we're travelling the same road, but the report was not authored by us. Certainly, I think it's a report we find a lot of agreement with, but if you find you need to make remarks outside the scope of that report, feel free to do so.

Dr. Paul Mulzer: That would be excellent. I do want to limit some to the report, and certainly I'm very happy to speak outside of the report and welcome questions as well.

I won't belabour most of the issues within the report. I thought there were some extremely important points raised in the document as well. Particularly on page 16, where they talked about the impact of the expenditure of a dollar spent on mental health care, the \$7 in terms of health cost savings and \$30 of actual productivity and social cost savings, it seems like, as a stimulus incentive expenditure, it may be one of the most fruitful and productive ones the government may encounter. So really, again, we see the need to fund this initiative appropriately. There's some degree of scepticism that some of the objectives that one wishes to achieve can actually be successfully achieved without an infusion of new

capital. Again, I'm not an accountant, but I see that as logistically an extremely difficult process to achieve without that.

I certainly see the stigma for our patients as a barrier to access and care. We also see the stigma as care providers. I think this becomes a very critical issue when you talk about recruitment and retention. I think of the great Biblical quote, "The harvest is plentiful and the labourers are few." One of the difficulties with recruitment—and of course the other challenge is the aging of our profession—is that we're a very stigmatized profession. There is a sense of disregard for the role that psychiatrists play in teams. Quite frankly, Every Door is the Right Door has the flavour of that in its document as well. There are some issues that we have with its minimization of the importance of treatment as part of comprehensive care. We see those things as being a very critical part of it. There's a tendency to have a reactive/proactive kind of discussion in that document. We see a need to be proactive and reactive to some of the crisis issues that we see as well, so I don't see those as mutually exclusive issues.

There's a tremendous amount of stigma and misinformation. It's not limited to individuals of the public. We certainly see it professionally. There's a fair amount of ignorance even among our professional colleagues that we contend with on a regular basis. These are significant barriers for care acquisition that make people reluctant to access it. They make medical students reluctant to consider psychiatry as an area of specialty, which is very unfortunate.

I joke with my students that we're the area of medicine where something doesn't go "beep." Basically, our tool, our instrument, is the effective relationship we establish with patients, and we have the great Hippocratic tradition, so it's really the ability to establish relationships and build rapport. That's the fundamental foundation of all treatment. I think that's a marvellous thing. It's why I went into psychiatry, so I don't have to worry about things that go "beep"—jokingly. Things get funded if they go "beep"; if they don't go "beep," they don't get funded. We recognize that as well in terms of research and development in mental health. I think one of the greatest strengths we have in this profession is that relationship, and it's really a wonderful relationship we have with the patients.

My particular field is both in mental health and addictions. Concurrent disorders has been a field where there's been a real burgeoning of interest, but it has really been in the last two or three years, remarkably, because of course it has been an issue, as Sandra eloquently stated earlier, throughout our history of mental health care delivery, whether we talk about opiates around the turn of the century or our current crisis here in the northwest.

I think we need to recognize that the challenges that we face are really integrating those services effectively. They do exist as silos. They exist as silos largely because addictions was never considered a legitimate field of medicine, and there are some people who would still challenge that even today despite clear evidence to the

contrary. That becomes an important challenge in terms of recruitment, service provision and integration of services.

I do refer to the document Every Door is the Right Door as well, and the idea of the provider-driven health care system. I've personally been in practice now for just over 20 years. I've never seen provider-driven care. I've seen administratively driven care, but not provider-driven. I have very little control over the allocation of resources. I'm very seldom directly consulted, as is true of many of my colleagues, on how resources are allocated, which is extremely unfortunate. I use the term "administratively centred." I think patient-centred care is a goal that we can achieve; I think it's one we need to achieve. It's a very critical one. But I frankly don't think the barrier to it is the provider.

I think, again, it's a really stigmatizing issue. We frequently see the comments of the psychiatrists as a barrier to change in the system. I've never seen that. I've not seen it from the period of deinstitutionalization of psychiatry, through our entire history of psychiatry. That's not been the issue; that's not been the barrier that I've seen. The barriers are really largely issues around funding models provision, and mandates that are established by various ministries.

The comments that I frequently hear aren't among therapists who are prepared to integrate services; they are among administrative systems that say, "That's not my mandate," or "How are we going to fund that?" or "Who's going to pay for that? I like that integration, but who's going to pay for that service?" To me, that takes us away from patient-centred care, and I see those as administratively driven concerns. I see them as having tremendous medical implications, but the root is not with us as providers. I think if you leave with nothing else, that may be the element of folklore, almost, because it has reached the level of folklore, that needs to be dispelled. It's probably one of the most important barriers.

I think we need to fund. I think we need to fund research and we need to fund addictions services, and education is a critical part of that. Certainly, rampant opiate addiction is an issue around education. It stigmatizes two groups. One is the addicted patient who has found himself or herself addicted to prescription opiates, and the other is the chronic pain patient who has no addiction at all but can't access chronic pain care medication and is in a state of tremendous distress as well. We need to recognize both of those two poles of distress and we need to be very mindful of the skill set required in order to meet both of those needs.

I think the other critical issue is that centres of excellence exist outside of the GTA, and we need to recognize that. I have tremendous respect for CAMH as an organization, but it is not the voice for the province. It does often have the influence of government, but we need to look beyond that and recognize that we need to build centres of excellence elsewhere.

1030

I posted the ASAM exams for December 2008—I just pulled them off before I came here—because I'm curious

as to how many people sat the American Board of Addiction Medicine, which we consider our standard for addiction medicine in Canada; unfortunately, by proxy, we use the American standard. Thirty-three people sat the exam in the entire country, 19 in Ontario, and most of those in the GTA. Again, CAMH seemed to have the lion's share of those, and Homewood Health Centre, North of Kitchener there were two, and I'm the only one in northwestern Ontario. That tells you, again, the harvest is great, the labourers are few. We need to promote the acquisition of skills in addiction medicine because we need to recognize its critical importance, and that needs to be disseminated.

Stigma needs a public education campaign. It's the same kind of aggressive campaign we looked at with HIV in the 1980s when people were concerned about sharing hand towels and "Can I drink out of that teacup because you've just handed it to me?"—all of those concerns. We attacked that with an aggressive public education campaign, and I think we need to do likewise when we look at issues of stigma around mental health and addictions. I think those are really critical.

The field of concurrent disorders, a field that I have tremendous passion for, is a rapidly growing field. It has very few practitioners within it. They are overburdened. They burn out. They go into general psychiatry. They do it at rapid speed so that those 19 that we have currently in our population that have just sat their boards—and I congratulate them for doing that. I hope they stay in that field; that's the other great concern I have for recruitment.

I think Sandra talked very well about the transition between youth and adolescent services. That's an area of real passion for myself. I see a lot of young people drop out of youth services at 16 or 17. I see them again at age 20 with full-blown addictions and hepatitis C status, and I think that's entirely a preventable level of morbidity that we really need to address. Those things are critical.

Issues around smoking cessation in our population and gym memberships to address things like metabolic syndrome may seem like simple interventions, but they have tremendous medical and overall health implications in the quality of life of our patients, which I think are really important.

Again, Sandra epitomizes, from my point of view—and I think she's a wonderful clinician—the motivation, the drive, the initiative of individuals within mental health and addiction, and that gives me great pride, and it gives me great hope for the future. I think we have some very fine people. I think they're very motivated to build comprehensive services, and I think the key is the opportunity.

I stress once more the importance of finances. I use a Jerry Maguire quote: "Show me the money." I cannot see these effectively being achieved without a massive infusion of capital.

Thank you very much.

The Chair (Mr. Kevin Daniel Flynn): Thank you. We appreciate the presentation. You've left about eight minutes for questions, so we'll start on this side with Liz.

Mrs. Liz Sandals: Actually, I'd like to go back to something that Sandra said and follow up on whether you have suggestions: her comments about the inability to start treatment with psychotropic drugs because there's no family physician to do follow-up. Given that a lot of the emergency clients will have a lifestyle that isn't going to lend itself to having a stable relationship with a family physician, how do you get around that? You're not likely to solve the problem of having them have a family physician. Is it an outpatient follow-up or having a nurse follow up? How do you manage that problem?

Dr. Paul Mulzer: Unfortunately, that's a very critical problem because those patients will frequently drop out of service provision because there will be no consistent provider of care. That's a very, very critical problem. Some of them will begin to use the after-hours clinic, the nurse practitioner clinics etc. to try and bridge that gap, but very frequently those individuals will be the ones, to use the analogy, falling through the cracks, who will actually not have ongoing care because they may not be connected to outpatient services.

The other issue is that patients in crisis who are really distressed may actually need someone back to navigate through the system to make sure of that follow-up. It's the power of making a phone call. One of our case managers had a recent situation with a client. Because he didn't respond to our appointment, we went and found him. He said, "Jeez, you know, we really appreciate you doing that, because you guys really are interested in our well-being." Those are important, especially early on in therapeutic relationships to establish that connection, but this would be precisely the patient where that would be very likely not to happen.

Mrs. Liz Sandals: So even if you can connect to do the initial intervention, we need to look at how you then follow that up in a stable sort of way.

Dr. Paul Mulzer: Absolutely.

The Chair (Mr. Kevin Daniel Flynn): Are there any other questions? Christine? Sylvia?

Mrs. Christine Elliott: Thank you very much, Dr. Mulzer, for joining us today. I think you've given us an important perspective from a professional perspective. I'm really interested in the education of physicians and what you would recommend to assist primarily family physicians in recognizing and dealing with mental health issues as they present in their offices: what's missing from education now, if anything, and what you would recommend.

Dr. Paul Mulzer: There are some really good initiatives. The OCFP, the Ontario college of family practice, has a program called MMAP, which is really to provide support to family doctors. It's sort of like a mentorship program around addictions and mental health. Sandra Sass and myself serve in the northwest region. That's a really important initiative to begin to have that mentoring relationship where questions can be asked around medications and managing more challenging clients and can be done in an informal setting where we'll be setting up to do a social thing, which is part of the equation of

building those relationships. I think those resources can be very helpful and I think it's a very good initiative of the college of family practice.

Other initiatives would be around free—and I always stress free, because physicians are attracted to free—podcasts and other things that would allow you to do some online CME, which can be very helpful.

I think funding initiatives and resources, where I would fund an opportunity for speakers to present on various addiction topics, might be very timely in the northwest—for example, on opiate addictions etc.—at some of those conferences where some of that information can begin to be disseminated. I think those are very helpful.

And I think just a bank of presentations much like Telehealth has, where you can access various topics on addictions, can sometimes be very useful too, where someone in their down time can begin to explore that. Again, looking for CME—and free CME is often a real inducer. So I think creating those kinds of resources could be very helpful.

Mrs. Christine Elliott: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Paul. I have a question. During our hearings in Kingston we heard from the former chief of psychiatry at Kingston General talking about what was a perceived lack of psychiatrists and child psychiatrists in his community. His point, if I can sort of paraphrase him, was that there is no shortage of psychiatrists in Kingston; in fact, there are over 40. The problem is, less than 10 will see a patient. If I recall correctly, it was less than five would actually see a patient; the others were all doing research at Queen's, I think it was.

What percentage of people who are psychiatrists actually see patients in the province of Ontario?

Dr. Paul Mulzer: I can't give you that number. I actually don't have that number, but I think you raise a very important point. Academics is incredibly important and funding research is important, but not disproportionately. Again, not to speak to Kingston's specific challenges, but to speak in general across the province, that balance of academic to service delivery is a critical one. I think, yes, you can on paper have some very impressive numbers but it really is how many people are doing—that's why I don't seek promotion, because I like to do clinical things. I actually try and let other people do the administrative stuff.

One of the problems, as people develop and go through the system, is their administrative load increases and their clinical contact load can decrease. That wouldn't just be true of psychiatry; it would really be across a specialty issue. I think that's a legitimate concern, and certainly if you're talking 10 clinically, 40 actually in the community, I'd call that a major concern in that particular community.

Around children in general, though, I think the issue around specific recruitment for children and incentives for child psychiatry becomes very important. Psychiatry, as you know, is one of the more poorly remunerated of

all specialties. Psychiatry, pediatrics and geriatric medicine are probably the poorest remunerated among all specialties, which is quite ironic, but it is what it is. What's interesting is that if you look among private practice child psychiatrists, they're the most poorly remunerated among all psychiatrists. So again, we need to recognize that it's funding models, resource allocation. All those things impact people's specialty selections when they're in medical schools, their formative years. Those are not insignificant variables that people look at as well.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for joining us today.

Dr. Paul Mulzer: My pleasure. Thank you.

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JOHN HOWARD SOCIETY OF THUNDER BAY AND DISTRICT

The Chair (Mr. Kevin Daniel Flynn): Our next presenter is the John Howard Society. Would Liisa Leskowski like to come forward?

Interjection.

The Chair (Mr. Kevin Daniel Flynn): You don't have any hockey sticks? Make yourself comfortable. There are some clean glasses there if you need some water. You've got 20 minutes; you can use that any way you see fit. If you want to leave a little bit of time at the end for questions, that would be great too.

Ms. Liisa Leskowski: Okay. I've tried to time this for 15 minutes so we'd have some time. You have the hand-out that goes with my presentation—the coloured one. It kind of outlines the main points of discussion.

Thank you for giving me the opportunity to make a presentation before you today. What I will share is largely based on my experience as a service provider, but I can assure you that these same experiences reflect numerous community-based agencies in Thunder Bay and in the 18 John Howard Society affiliates across the province. Our collective concern for the numbers of clients we support with mental health and addictions issues, coupled with how resources have been allocated by provincial ministries in the past five-plus years, has been much cause of discussion and concern among ourselves and is really the impetus for my request to meet with you today.

My name is Liisa Leskowski, and I'm the executive director of the John Howard Society in Thunder Bay. As a community-based criminal justice organization, our mandate is to support people who are at risk or involved in the criminal justice system through service, advocacy, education and reform. We serve individuals involved in the correctional system, the court system and the educational system, and in First Nations communities. The John Howard Society of Thunder Bay provides supportive housing in a 48-unit housing facility, and we deliver programs with the courts and corrections systems, and community-based programs to individuals in conflict with the law.

Each year, thousands of individuals—men, women and youth—come through our doors for support. I would estimate that 70% of them have an addictions issue and 40% to 50%—and I think that's modest—suffer from a mental health issue. We do our best to provide necessary front-line support, engaging as many of our mental health partners as possible. Some of the things we've done in the past number of years: just this past year, since there have been more mental health workers in the community, having mental health workers come on-site; we have a nurse practitioner that we get to come on-site; and we've attempted to have a mental health nurse on-site in our building. Unfortunately, these collaborations have had a really limited impact.

I believe that timely and thorough assessments and early identification and case management are essential and required, but equally essential is the provision of direct front-line support in the community, provided not just on a 9-to-5 weekday schedule but reflective of the episodic nature of someone suffering with a mental illness or addiction. Because we provide housing in addition to daytime programming, counselling and support, we are consistently on our own when it comes to providing support for our clients with an addiction or mental illness. To illustrate this, I'd like to share a story of one of our clients. I'll call him John.

John came to live with us after his release from a local correctional facility. He had a diagnosis of paranoid schizophrenia, and we were advised that it was manageable with medication. He had violent tendencies, which were noted by his Ontario disability worker, his probation officer and his mental health worker. He suffered from depression, and a few weeks after his release he refused to take his medication and became increasingly agitated and depressed. After threatening numerous of our residents with a knife, followed by just as many warnings, we advised him that he could no longer continue living in our facility.

In an attempt to find him alternate housing that did not put the community at risk, we discovered that he had been banned from all other housing providers in the city, including the emergency shelters. Fearing that we would be putting the community at risk, we allowed him to stay with us until we could find him housing. So we went out and found him housing. He moved into his own place, and a month later he made headlines in our local paper for assaulting a taxi driver with a knife and was subsequently charged and incarcerated. This would have been two years ago, so I'm assuming he has been released by now.

John is one individual, but his story represents hundreds of individuals we support each and every year who face the same challenges compounded by a mental illness and addiction. John's story might have been different had we had the resources to provide the front-line, one-on-one support he needed. Unfortunately, there are virtually no sources of funding—health or otherwise—for us to tap into to hire mental health workers to provide this essential support to our clients. It is woefully

inadequate to have mental health workers come on-site for two hours a week and expect us to make referrals to them—they do assessments—and assume that there's any assistance for us.

I've been with the John Howard Society almost four years. I found out about the provincial funding in 2006. When I discovered that the province was beginning to spend money on mental health issues for individuals in conflict with the law, I became encouraged and understandably excited. My excitement quickly turned to disappointment and frustration when I began to understand that none of the resources that were being allocated would be coming our way. We were advised that only agencies that had health numbers would be eligible for funding from the province. In fact, community criminal justice organizations were largely excluded not only from the funding but from the advisory groups and the planning tables, despite the fact that we serve some of the highest-risk and highest-needs clients in the social service sector.

Individuals with a mental health concern who have criminal justice involvement often walk through our doors first. They come to us because we are known to provide services that are accessible, welcoming, safe and knowledgeable. Those who have experience within the criminal justice system know who the John Howard Society is. We know more about the language, experience and challenges of this group, because we specialize in this area. Our staff have credibility with this client group and have developed unique skills to ensure we are best meeting client needs. Criminal justice organizations include the 18 John Howard Society affiliates throughout the province, the Elizabeth Fry Society, Salvation Army, St. Leonard's House and a host of other agencies.

As funding was rolled out for mental health and addictions workers a few years ago, they joined us in the trenches, working with individuals in conflict with the law. But the lack of awareness of our work and the separate streams of service, isolated and disconnected from existing community criminal justice services, created an overlap of services at the ground level. As well, it did not address the huge gaps in service we experienced.

An example of this would be when a mental health discharge worker claimed at a reporting forum to have found housing in our community for a client—these numbers of the work they're doing are then sent to the ministry. In fact, that housing was in the John Howard Society supportive housing facility. He was one of our clients, and he had never even been seen by this worker outside the institution. We provided the individual with food, shelter, clothing, supportive programming, and pre- and post-discharge services, with none of these services provided by funding from the Ministry of Health. All these services that target the social determinants of health prevent health crises. Without funding, we cannot provide the level of mental health support required by our clients each day, and each day another client like John falls through the cracks.

True collaboration is more than co-operation; it is the sharing of expertise and resources, both internal and

external. It is creating something far greater than one agency or sector can by working alone. If only one sector receives the funding, there will be no true collaboration. Changing lives and supporting individuals who face mental health and addictions issues cannot be done by one agency, one sector working alone. All systems must work in partnership. I can tell you that those collaborations do not exist on a rubber-meets-the-road community level. True collaboration will only happen when resources are shared.

Although the provincial Human Services and Justice Coordinating Committee response to the 10-year mental health Every Door is the Right Door strategy suggested that resources need to flow through the health system, I strongly disagree. The resources should flow through the systems where the clients are, whether that be an emergency shelter, a community-based criminal justice organization or a traditional health provider. As chair of the Thunder Bay District Human Services and Justice Coordinating Committee, I have seen the benefits and challenges of developing a strategy to address these issues. These committees are beneficial for knowledge sharing and for networking but they are not collaborations. This work does not translate to on-the-ground support for individuals or the agency that provides it.

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There is as much serious, meaningful, full-service, evidence-based provision going on every day in agencies just like ours as there is in any local mental health agency that may have come to speak to you today. Our post-secondary educational requirements for employees are the same as those required by traditional health service providers. If this 10-year strategy continues to fund as the province has funded the Human Services and Justice Coordinating Committees, the HSJCCs, the services and the support will not reach the individuals who suffer with the mental health and addictions issues who come through our doors. I strongly believe that the money should follow the client through the door if you truly mean every door to be the right one. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Liisa. You've left about nine minutes for questions. We'll start with Sylvia.

Ms. Sylvia Jones: Thank you for your presentation. You mentioned that you now have a mental health—

Ms. Liisa Leskowi: We've tried to create partnerships with mental health organizations that have the funding to deliver the services to bring them into our facilities. They're not coming in at the moment, but once a week they would come in on Wednesday afternoons and they would take referrals from us to do assessments.

Ms. Sylvia Jones: Your point is that they are simply not enough hours—

Ms. Liisa Leskowi: Nowhere near the support. An assessment is great; they'll do an assessment. But at the end of the day, in the evening, on the weekend, when someone's having a psychotic episode and he's in my facility, I have no funding. We call the police. We take them to emergency. There's nobody there to provide the

support for that individual or to work with them. There's no wraparound individual.

If I had three full-time mental health workers, that would be fantastic. They would work with the mental health clients. But having someone come in for two hours a week to do just an assessment? They don't do front-line support. That's my issue.

Ms. Sylvia Jones: One of the recurring themes that's coming up as we hear the deputations is this—it's a poor phrase, but continuum case—

Ms. Liisa Leskowi: Case management.

Ms. Sylvia Jones: Case management. Yes. Would you envision that kind of role?

Ms. Liisa Leskowi: Okay, I'll get on my other soap box. Case management is important; it's great. You need to get all the players to the table to talk about it. But we don't need another case management model. What we need is front-line individuals willing to do the work. There's case management going on—every agency seems to get funded to do case management: "Let's all get together and talk about what we're going to do." But at the end of the day, who's helping that client if they're living in a shelter, if they're living in my facility? We run a completely unfunded 48-unit housing facility. Individuals in conflict with the law: Half of them have mental illness.

Ms. Sylvia Jones: Would part of the argument for the case management be that in fact as they go through the various agencies that you're—

Ms. Liisa Leskowi: A case manager works Monday to Friday, 9 to 5, and expects that mental health client to come to a meeting. I'm talking about a worker who can be available for that individual, then go to the case management. You can put the case management in place so that the worker has to come to them and discuss, but who's providing that front-line support after that case management meeting?

Ms. Sylvia Jones: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Any questions from this side?

Who funds the John Howard Society in totality? Out of all the money you spend, where does it come from?

Ms. Liisa Leskowi: Okay. We are funded under various ministries to deliver certain sectors of our work. So for example, we get money from the Ministry of the Attorney General to deliver a bail program. These are individuals released into the community who are at low risk, and we do their supervision. We get funding to deliver programs such as community service supervision. We deliver a remote aboriginal intervention program with youth. We deliver a school-based diversion program and we do reintegration work, so we get United Way dollars that fund a worker who goes and does discharge planning at our local correctional facilities.

There is no ministry that will fund housing for this client group in the community. I have barked up every tree and tried to get funding, so we get funding, for example, from the Ministry of the Attorney General to deliver a bail program. Of those clients, 48 every month

are living in, and they rotate through, our building. They won't give us any money for housing. No one gives us money for housing. It's not in anybody's mandate. We fall between jurisdictional gaps and ministry mandates to deliver housing for this client group.

We do it on a business case model, so we are able to—we get United Way dollars to pay for the staff, the housing manager and my reintegration coordinator. We get almost every—well, not almost. Every individual is on Ontario Works or ODSP, which means they get their rental portion. We are able to collect that rental portion and we're able to provide a room and a shared kitchen—they go to the shelter house and eat—but it's a safe, secure facility.

We made the decision a number of years ago to provide housing because we found it completely ineffective, for an individual who was coming out of jail, who had a mental illness or who had an addictions issue, to deliver a program—whether it was anger management; life skills; anti-criminal thinking; substance use programs, which we deliver on a regular basis—if the person was living in the shelter or didn't have stable housing. The only way we felt that we could provide effective service to make them change their lives was to provide the housing.

So we run our housing on a shoestring, but we know that we change lives because we do it. We've just gone out on a limb and done it.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much, Liisa, for coming today. Oh, sorry, Liz?

Mrs. Liz Sandals: Thank you very much for sharing that information with us. You just mentioned that you get funding—well, you get the ODSP rent allowance but you also get United Way funding. My experience with the John Howard Society is that they're not providers of housing, so in—

Ms. Liisa Leskowski: It's unique in Thunder Bay.

Mrs. Liz Sandals: Okay, that's what I was going to say, that the model—

Ms. Liisa Leskowski: Yes. There are John Howard societies that do do housing, but they're usually ministry funded. I think Ottawa has numerous houses, but it's either by Corrections Canada or it's by the Ministry of Children and Youth Services.

We are unique in our housing model, absolutely.

Mrs. Liz Sandals: My experience is that John Howard is not normally a housing provider. John Howard is usually the provider of the services you list—

Ms. Liisa Leskowski: Yes, that's right, and we do both.

Mrs. Liz Sandals: —and the rest is funded by the justice system. Okay, that's helpful to get that clarified.

Ms. Liisa Leskowski: And I think for us in Thunder Bay, because we service so many outlying northern remote communities and a population that's 70% aboriginal, it was absolutely imperative that, to be able to have any success, you provided housing.

Mrs. Liz Sandals: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you for coming today, Liisa. It's appreciated.

NORTH OF SUPERIOR COUNSELLING PROGRAMS

The Chair (Mr. Kevin Daniel Flynn): Next is our 11 o'clock appointment, North of Superior Counselling Programs: Bastian De Peuter and Laurie Knutson.

Ms. Laurie Knutson: Good morning.

The Chair (Mr. Kevin Daniel Flynn): Good morning. Thank you very much for coming this morning. Like all other delegations, you get 20 minutes. You can use that any way you see fit. If you can leave some time at the end for questions, that would be appreciated. There are some clean glasses and some water if you need it. Other than that, we're all yours.

Mr. Bastian De Peuter: All right. Thank you.

North of Superior Counselling Programs is honoured to be here today. My name is Bastian De Peuter, executive director of North of Superior Counselling Programs. With me today is Laurie Knutson, director of adult mental health and addiction services. We appreciate that there is a great deal of effort taking place on both a provincial and federal level to address the issues of mental health and addictions, and to come up with strategies that better meet the needs of Canadians of all ages in our province. We welcome you to Thunder Bay and hope that our presentation may remain in your memory, and in some small way inform the important work that lies ahead of you. We cannot ask for more than this.

Our presentation for the Select Committee on Mental Health and Addictions today is on why rural mental health matters.

North of Superior Counselling Programs is a small rural community mental health agency serving children, families, adults and seniors. Our offices are located in Nipigon, Schreiber, Marathon, Manitouwadge, Longlac and Geraldton. Our mental health staff serves people in 13 rural communities and five First Nations in the surrounding areas. If you were to go to each one of the offices, starting in Nipigon, in the communities we serve, and going back to Nipigon, it would take you 12 hours of uninterrupted driving between the farthest offices in the communities we serve—and that's going the speed limit. Our agency's catchment area covers a vast geographical area of over 80,000 square kilometres.

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Our agency is special to us because it is filled with good people doing lots of good work within very limited budgets, and in that way we are like every other rural community mental health agency. Our agency services a shrinking population, increasingly comprised of baby boomers and beyond. Many of the communities that we serve have been largely mono-economy towns depending on the forestry industry. This industry has all but vanished. The social and economic ramifications are obvious and have occurred many times across Canada in boom-and-bust industries.

The people who utilize our services are not more important than those living elsewhere, but it must be said,

similarly, that neither are they less important than people living in large urban centres, mid-range cities or any other rural part of Ontario. Yet rural citizens have access to a much smaller range of mental health and addictions services than do people living in more populated locales.

The Mental Health Commission of Canada this year released its framework for a mental health strategy for Canada, entitled *Toward Recovery and Well-Being*. The province of Ontario has also addressed its 10-year strategy for mental health and addictions, and we commend the great effort of many dedicated, intelligent people on doing this valuable work. It's not our intention to reflect on those documents *per se*; it is our intention to use our allotted time to discuss how rural mental health and addictions services may have unique needs. Rural practice may also have gifts and insights to share with people in much different ways.

The fallacy of formulaic funding: While the 10-year Ontario strategy for mental health and addictions allows that there is no health without mental health, the funding allotted for rural mental health and addictions says differently. Under the underserved areas program, the Ministry of Health and Long-Term Care has allotted the communities we serve with the ability to hire 27.5 medical doctors at their full complement. Between our agency and the two already-funded family health teams in our district, there are only seven full-time equivalents for adult mental health and addictions. We are delighted that medical doctors are seen as the necessity that they are. We are simply appalled that mental health and addictions is seen by the same funding ministry as not as important to deserve similar resources.

Our agency is funded for five adult mental health and addictions counsellors, 7.5 children's workers, and five ISNC—integrated services for northern children—case managers for special-needs youth. There are also the two social workers currently working for family health teams in the district. However, the funding disparities are abhorrent. The funding for medical doctors, who are at the top of the financial food chain, is out of balance. This does not mean that we would wish that our communities have fewer doctors allotted; we only wish that we were funded more equitably.

Funding also fails to account for the inevitable reality that costs per service unit are going to be higher in rural, multi-site agencies. We maintain six offices, all of which require the same technology access and equipment. An agency of 25 to 30 people in a more urban centre supports only one rental agreement, one fax etc. Multi-site agencies cannot be compared on those cost efficiencies.

The increased costs in rural areas are those of travel and training. Our staff are often required to travel to various communities, and therefore the cost of such expenses will be higher than in urban communities. This is also true for staff development, training and recruitment of staff.

The question that we are left with is, what will it cost the medical system of this province and this country to not adequately fund rural mental health and addictions

for all ages? We suggest that if mental health continues to be grossly underfunded, rural communities will show increasing loss of hope, economic viability and community cohesion.

Ms. Laurie Knutson: We are also wishing that the funding we receive would allow for more multiple levels of care. Currently we are funded to do primarily counselling for children, families and adults. These are the highest-level services that we can deliver, and they are delivered by the best-trained professionals that we can attract to the district. There can be no compromises here. We are proud of the gains we have made in professionalizing the staff.

However, we have people attending counselling who could benefit from care delivered by people with less training and thus assure that the utilized therapy is absolutely needed. However, we are not funded for the community support workers or behavioural interventionists in the school that could address situations out of a formal setting and therefore be more cost-effective.

And if you are unfortunate enough to be born in the rural district and you have any kind of developmental delay or extreme medical problem, you just need to pack your bags and move to the nearest city as soon as possible, because you will hardly be serviced at all.

We are also suggesting that there is a huge need for increased tele-video and tele-site facilities.

Just a test now: Were you listening? How many adult mental health staff do I have for all these communities? Five. Okay? Thirteen communities, First Nation communities, six offices: I don't have one adult mental health and addictions counsellor per community.

The best one that I have to deliver one service may be in this corner, and that specific skill that he or she has is needed in the far corner. I can put them six hours down the road to deliver this service. If I had capacity to have tele-video, I could have that person link across the district. Yes, we have access to use those at the hospital. However, we will get bumped if it is needed for a medical consult or for training for nurses or doctors. That is as it should be. We need more capacity across the system to deliver tele-mental health.

There are usually funds available to help purchase the equipment, but keeping the lines viable and going is a costly venture which I think would cost the equivalent of almost one FTE for the year. It's too expensive. Small agencies cannot sustain this cost on their own.

Crisis care: I'm not going to spend much time on that. You've already heard some of the issues, from Paul Mulzer and other people, about the need for more crisis care.

In rural communities, the hospital emergency room after 5 o'clock is it. When regional says that it's closed to the district, it can be closed to the district. Therefore, a psychiatric crisis is what the doctors can provide in the hospital, which is not a psych bed, and there's a number that we can provide for telephone counselling in Thunder Bay.

There are times when a more secure hospital setting is required, to keep our clients and individuals safe from

harm or risk of suicide. Unfortunately, these resources are not available in our communities. Therefore clients are escorted by ambulance and police to Thunder Bay. This is disruptive to the clients and their families and takes police off the streets. It's a problem that we need to solve.

Dr. Mulzer has also addressed the extremely limited psychiatric care that's available in the districts.

Can I ask how we're doing for time?

The Chair (Mr. Kevin Daniel Flynn): I'm just trying to get this on my BlackBerry. You've got about nine minutes. You're about halfway.

Ms. Laurie Knutson: Okay. Services for seniors: Northern Ontario is aging at a faster rate than the rest of Ontario. In northwestern Ontario virtually all but First Nations communities reflect this trend. This trend will mean increased demands for social service and health care supports, including mental health services. This will also mean increased training for the staff that we do have, who are expected to do everything in adult mental health.

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The problem of addictions: We know that addictions and mental health go hand in hand and concurrent disorders are not only the rage of the day but the reality of the day. If you live in a district that doesn't have anywhere in its catchment area a movie theatre, precious few cultural events and a teen population with diminishing pro-social activities in which to participate, the weekends are going to be filled with less healthful activities, may we say, such as alcohol and drug use. Sometimes it gobbles up the week as well. These have become normative in many of our communities. The tri-task force that covers the areas around Thunder Bay is busy doing drug raids in the region.

We are proud to say that one of our communities has the highest cost for street drugs anywhere in Ontario, and that's due to supply and demand. A Percocet on the streets of Longlac will sell for \$12.50 for one pill; OxyContin, 20 milligrams, 40 bucks, 80 milligrams, \$120 per pill. There are people locking their refrigerators and their food cupboards to keep their family members from stealing food because whatever money they have is being spent on this insidious opioid problem.

We have the largest community in our district that does not even have AA. There is no NA in the district, and several of the smaller communities have AA. The province spends a huge amount of money sending people to treatment and then sends them back into communities in which there are either no or limited supports. That's like throwing water down the toilet. We need to resolve this.

Getting everyone to shoulder their fair share: Our agency and likely all rural community mental health agencies are asked to deliver more than they are able to do with their funded resources. For example, in our communities, as the loss of jobs has caused out-migration and depressed housing prices, we are seeing the composition of the communities change. New entrants to the

community are likely retirees or people on disabilities who may not be able to afford a nice home elsewhere.

There is also a concomitant rise of those with legal histories. Currently, we are asked to provide services for probation and parole clients from both the provincial and federal systems. Our services are meant to be voluntary, yet all of these people entering our system with orders from a judge to attend are usually required to attend for drug and alcohol assessment and anger management. Often they are referred to PAR training, for those who have been assaultive in their families. The problem is that there is no PAR training in our district. We would love to provide this, but my five adult workers cannot adequately meet the needs of the voluntary clients as well as the mandated clients coming through our doors. The Ministry of the Attorney General and the prison system need to carry some, if not all, of the costs of these programs. I suggest I would currently need two FTEs just to form the forensic team to meet the needs in our district.

Similarly, there are increasing pressures on the school system and our agency to collaborate. We would love to do this. It's a great idea to have more social workers in schools. I just can't pull them out of the sky.

Forging linkages beyond the usual suspects: In our communities, the most likely collaborations have been with schools and the medical system. As our communities continue to change in size, demographics and socio-economic stability, mental health may need to forge more alliances beyond the traditional ones. We might likely need to link with municipalities and faith communities that are part of maintaining a vibrant community.

Increased focus on communities: Although we are funded as a community mental health centre, the concept of community has, in large fact, been an afterthought in the funding and delivery of services. With the exception of public education on subjects related to mental health and addictions and sitting in on the local communities with other stakeholders, the overall importance of the concept of "community" in community mental health has been given a seat at the back of the bus. Funding focuses have been on providing mental health services as if they are somehow distinct from living in community. As for actually using our resources to actively try to create communities, well, that is an idea whose time needs to arrive.

I'm going off-script here because I know we're running short of time.

Spirituality: It was mentioned in the Mental Health Commission of Canada as part of their thing—and I wish they would have taken it farther—that we in mental health need to quit being afraid of spirituality as a part of the healing. I am not talking about religion; I am talking about seeing interconnectedness as part of the healing. I wish that people could come to rural communities and see how they do this better, sometimes, than urban centres.

When the mill closed about two years ago in Terrace Bay, the food market—it's a small little food market, okay? It doesn't have all the nice things that are here in

Thunder Bay—let families charge their food. Where does that happen in a city? The community members are worried about the local businesses. They don't want the food market to close.

People in rural communities know something about support systems that we could actually take to the city. I'm going to suggest that maybe we move some of the treatment facilities out of the cities and let people come to places where they can heal because they're in nature, it's beautiful and it's part of their healing.

I'm going to stop.

Mr. Bastian De Peuter: Just to summarize, it is essential that a provincial mental health care strategy develop improvement to the existing lack of resources to save and enhance vital mental health services in Ontario's small, rural and northern communities. Everyone should have access to high-quality mental health services in the same way that they have a right to health care, no matter where they live. The local community mental health services are severely lacking resources during a time when the needs are greatest. We encourage the Select Committee on Mental Health and Addictions to create a mental health care strategy specifically for Ontario's small, rural and northern communities so people get the care they need and have a right to.

We are proposing a strategy that focuses on six essential requirements:

- adequate mental health and addiction services guaranteed in each rural community;

- 24/7 emergency room access for those seriously ill mental health patients who are in crisis, with access to specialized resources for consultation when required, even just for a brief period of time;

- early intervention, community information and public education on mental health issues;

- accountability and transparency guaranteed;

- fair, flexible and community-based funding guaranteed to small rural communities for mental health and addiction services for both children, families and adults; and

- continuum of care and mental health interventions between the age span and between funding ministries.

These strategies would include:

- recognizing that community mental health agencies have a close affiliation with local hospitals as the hubs of small, rural and northern communities;

- that there is delivery of local emergency care and mental health services;

- that they provide access to specialized psychiatric resources through telepsychiatry and regular, consistent locum visits to each rural community;

- establishing a rural mental health care staff recruitment and retention strategy;

- ensuring availability of early intervention and treatment for children with mental health problems;

- establishing a shared care strategy and create connectivity between hospitals, community mental health agencies and family health clinics;

- ensuring that ERs are open on a 24/7 basis for mental health patients in crisis when they need a psychiatric bed;

- creating a comprehensive awareness and education campaign to inform those living in small, rural and northern communities about mental health and addiction services;

- recognizing that the government, local health integration networks, hospital boards and community mental health agents must be accountable to the communities they serve;

- recognizing that funding needs are different in small, rural and northern communities; and

- creating guidelines for increased, fair and flexible funding based on community mental health and addiction needs instead of per capita funding.

We thank you for your time today and your interest in improving the mental health services to our northern rural communities in Ontario.

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The Chair (Mr. Kevin Daniel Flynn): Thank you, Bastian. Thank you, Laurie. A very thorough presentation. Unfortunately, we have no time for questions, but I think you got your point across very clearly.

Ms. Laurie Knutson: Thank you very much.

SCHIZOPHRENIA SOCIETY OF ONTARIO, THUNDER BAY

The Chair (Mr. Kevin Daniel Flynn): Our next speaker this morning is from the Schizophrenia Society of Ontario, Thunder Bay, George Tucker. George, if you'd like to come forward. Make yourself comfortable. There are some clean glasses of water over there if you need any water for your presentation.

George, everybody gets 20 minutes for their presentation. You sat through a few, I think. You get 20 minutes as well. You can use that any way you think you should, and if at the end there's any time for questions, we'll see if we can share it among everybody.

Mr. George Tucker: Good morning, everyone. Thank you for this opportunity to come and give my presentation. I'm going to begin quickly on the page underneath the cover page.

We are a chapter of the Schizophrenia Society of Ontario. Our purpose is to advocate with governments for better services, increase awareness of schizophrenia, educate the public about schizophrenia and provide support for families and people with schizophrenia. We continue to raise monies for research and better treatment for those who suffer from this biochemical brain disorder. These funds and research will lead to improved treatments and, ultimately, a cure.

Beginning on the next page, omitting that small top section there: Thank you for this opportunity to present the needs of people with mental health issues. As a volunteer mental health organization, we have many contacts with families and consumers. The needs are many and varied.

Studies done 20 or 30 years ago are still relevant today, as these needs have only been partly met. Up till now, there have been many fine terms used in describing the desired mental health system. Terms like "best practices" and "comprehensive and coordinated" litter the literature but have brought little substance to the effective treatment and support of the many who struggle with mental health issues.

Many times, the increased funding has been gobbled up by increasing costs. At one time, there were almost twice as many mental health beds in Thunder Bay. With the building of the new regional hospital, closing of the two older hospitals and phasing out of the psychiatric hospital, we have lost many of these beds. When we had those beds, they were needed, and we still need them.

Thunder Bay Regional Health Sciences Centre serves a large portion of northwestern Ontario. Many people with mental illnesses from smaller communities across our region end up in Thunder Bay looking for mental health services. This includes people from First Nations communities. There are 56 First Nations communities across northwestern Ontario. Many people from these communities come to Thunder Bay, and those with mental illness strain our already inadequate mental health services.

After deinstitutionalization was begun many years ago, Health Canada reported that people who once had been in mental institutions were appearing in jails. The reports also stated that most of these people were being criminalized because of behaviour motivated by symptoms of severe mental illness. At present, the token few who receive help are indeed fortunate, but there are many who are turned away. Our contacts from corrections inform us that one third of those in the correctional facility on Highway 61, Thunder Bay, have a mental illness.

The textbooks say that 40% of people with mental illness are not being treated. This has implications not only for worsening mental health: Because of the condition of severe mental illness, these people become unable to properly care for themselves or to seek needed health care. This has implications also for worsening general health across the population. This could have disastrous results because of homelessness, the inability to monitor the health of the homeless and the low level of health experienced by this population. Many of the homeless suffer with mental illness. The textbooks state that the mentally ill, in general, experience poorer physical health because their complaints are often ignored. In fact, the textbooks also state that the negative impact of mental illness worsens physical health.

Next, I would like to list the needs of the mentally ill: mental health beds as needed; access to psychiatrists; medications and other required treatments; safe, affordable housing; adequate community supports; and high-level support group homes.

As for the need for mental health beds, sometimes tragedies occur because the response is too little too late, as it is at present. To demonstrate some of these tra-

gedies, I would like to tell you about a man I knew who had a wife and several children. He developed a severe mental illness, and something was finally going to be done about it. One day during the waiting period for this help, he closed himself in a closet at home with his moose gun. When his wife and children heard the bang, they ran into the room in time to see the blood flow from under the closet door. What impact do you think this had on that family? Could there have been a better outcome if he had been hospitalized earlier? The 2006 Canadian edition of *Abnormal Psychology* and many other textbooks state that medications significantly reduce the prevalence of suicides.

For some years now, the aim has been to treat people in the community and avoid hospitalization. The problem is that many of the mentally ill are being treated even later now than they were before this began. One man had come out of the prison system after being in and out for some years. He had been in crime, was drug addicted and had five suicide attempts in six years. He was really tired of ending up back in jail. While he was in the Thunder Bay community, he expressed a desire to make it and stay out of jail. He talked about getting his life back and straightening up. It took almost a year to see a psychiatrist and by then he was starting to think nobody really cared, and his many problems caught up with him. He has been diagnosed with several mental illnesses which aggravate each other. By the time he finally got his medication changed, he was already unravelling. He had stayed off drugs and out of trouble for almost a year. He told us that that was the longest he had stayed out of jail. He started to hang around with drug-using friends and ended up in a cocaine psychosis. He did considerable damage in the apartment in which he resided before he was taken to hospital by police. Instead of being kept in hospital, he was released that same morning. He was evicted from his apartment and disappeared on the streets, stealing to feed his drug habit. From there, he returned to the prison system.

The system has surely failed this person, as it has failed many others as well, but instead of a lesson learned, we see collective shrugging of shoulders and always a blaming of those the system failed. Individuals certainly do have a responsibility, but it is well known and beyond dispute that mental illness makes it much harder for these individuals to take responsibility or even see their best interests.

The next situation is a woman with severe paranoid schizophrenia. She had been desperately hanging on for many years, highly symptomatic, her voices urging her to self harm or to take her own life. People like this person desperately attempt to achieve a sense of self and community amid all the craziness that swirls inside them. None of the medications reduced the severe symptoms enough so that she could live at peace within herself. She has to be on constant guard to prevent tragedy. She has been so unsure of herself, experiencing so much fear, that small daily hurdles would send her into a panic. She would go into a panic attack, scream out of control and

couldn't stop. Someone would have to straighten things out for her as she just could not even reason any more. Because of her paranoia, she was constantly thinking everyone was against her. When she recently got worse, she threw out or destroyed most of her prized possessions. She also became assaultive and received an eviction notice from her landlord.

1130

She had a case worker, but during her hardest times this was no help as she was so paranoid that she turned against her case worker. Her case worker was very afraid of her as she was very hostile towards this person. Everyone in her apartment building was afraid of her as she was hostile towards them and very confrontational, accusing them of things that were products of her own paranoia. She spent a fairly lengthy time in the hospital and has returned to the community. She is no longer actively hostile or assaultive and not in as much fear as before, but she has fired her case worker and homemaker and still does not trust many people.

This situation shows the need for mental health beds. There is no way she could have been treated or supported at home. She needed a hospital stay to ensure she got medication and got stabilized. She needed that time in a safe haven to keep her safe from herself and any harm that may have overtaken her in the community.

A man with severe paranoid schizophrenia recently relapsed and had to be taken to hospital by police. He had gone completely off his medication. He was hallucinating and saw and heard things that meant to him that there was immediate danger. "The enemy" had come for him and he made a complete shambles of his apartment in the fight to save himself. All his furnishings were upset, and there were damages to repair and things to replace. He was completely into his own world of his hallucinations, constantly believing he was in danger. When the police had arrived, he was all alone in his apartment fighting off imaginary enemies.

In these most difficult times in this person's experience, he must be in hospital to keep him and others safe and get him back on medication. He has to have enough time in hospital to make him stable enough so that he can continue to function well and prevent relapse.

The people in these true examples I have given to you could not be treated and supported at home. They are too out of control, especially when the person believes he or she has to defend him or herself. Outside of a safe environment and living on their own, these people have access to things that can be used to harm themselves or others, such as knives in the kitchen. When a person is out of control, anyone bringing medications or other help, persons such as support workers or a homemaker etc., are at risk of injury or even death.

There are a fair number of people who remain untreated and unsupported and cannot gain access to treatment, and those who come to help are at risk. These people are uncared for and just disappear off the radar and are forgotten. Then, when the mental illness urges them to desperate acts, it becomes a matter for the criminal

justice system. When it gets to that stage, sometimes something terrible has happened. This is a tragedy for the families of the victim and the families of the mentally ill person who committed the act. Why we wait for the worst-case scenario I shall never understand.

There was the beheading on a Greyhound bus in Manitoba and the knife attack on a Greyhound bus outside White River, Ontario. In both incidents, the perpetrators suffered from schizophrenia. In the second incident, the man had gone to a hospital for treatment and was turned away.

When these tragedies happen, if anyone questions the reasons, there is just a collective shrugging of shoulders and no one has learned anything. No one is held responsible. No one is accountable. If these tragedies happened involving a failure to treat a physical disorder, there would be a hue and cry, but because it only involves mental illness, we hardly even hear a whimper.

The severe mental illnesses like schizophrenia are not taken seriously, even when injury or death comes as a result of non-treatment. A large percentage of families of the mentally ill are caregivers and some have a severely mentally ill family member living at home. There is no recognition of how hard this is for families.

I remember looking into the eyes of a mother who was—pardon me.

The Chair (Mr. Kevin Daniel Flynn): Take your time. We have lots of time.

Mr. George Tucker: Thank you—who was telling me her story. Her eyes were just black holes; there was no life left in them. She was totally exhausted. She looked ready to drop right there in front of me. She has no life; she has nothing. This is a life worse than death, and she is not the only one. There are others. There should be more high-level support group homes for those who are too much for their families. There are families who fear for themselves because they cannot get adequate treatment or care for their mentally ill family member.

In Ontario, there are families who barricade their doors at night because they fear for themselves and cannot get help for their sick loved ones. These families cannot get relief from burdens that are crushing the life out of them. It is too hard to get into hospital. It is too hard to see a psychiatrist. It is too hard to get treatment.

Many of the things the mentally ill have to do in the community are so hard that their stress and danger of relapse is increased. They have enough fear already from their illness, and many of the criteria they have to meet in order to live in the community cause increased fear and distress. Most people with severe mental illnesses, like schizophrenia, relapse. Many of the small stresses contribute to a total of stresses that causes relapse. This increases the numbers and duration of hospital stays and many other attendant negatives.

We need psychotic disorders like schizophrenia to be taken seriously. At present, many people remain untreated even when they ask for help.

To repeat, the needs are mental health beds; access to psychiatrists; access to treatment/medications; safe

affordable housing; adequate support; and high-level support group homes.

Thank you for this opportunity to present our concerns. Will there be any questions?

The Chair (Mr. Kevin Daniel Flynn): I'm sure there are. Thank you, George. You've left us about maybe four minutes, so there's time for a couple of questions. Howard, do you have anything? You'd be next in rotation.

Mr. Howard Hampton: I'm not sure this is a fair question, but there used to be a psychiatric hospital here in Thunder Bay.

Mr. George Tucker: There still is. It's downsized. At present, they're just running one small ward containing from about 50 to 75 people.

Mr. Howard Hampton: When that hospital was downsized, the public was told—and we're talking here over many years—that more services would be available in community hospitals, more services would be available in the community. Is that true? Is that what happened?

Mr. George Tucker: That's not what happened at all.

Mr. Howard Hampton: What happened?

Mr. George Tucker: What happened is that after de-institutionalization and they were sent back into their community, the services were not there. We have a large mentally ill population on the streets. The Salvation Army, just a few years ago, reported that 75% of their clients have a mental illness. The other—a housing corporation reports that a 50-plus number of their clients have a mental illness. There is not the support. There is not enough support for these individuals.

For some individuals, no amount of support would be adequate for them, they are just too sick, and a number of them require a great deal of support which is not available. The support systems are stretched to the limit. Funding does not require them to support—and they're not supporting all; they're only supporting a portion of those who require support.

The Chair (Mr. Kevin Daniel Flynn): Thank you, George. Helena?

Ms. Helena Jaczek: Thank you very much, Mr. Tucker. Rest assured we're here, we're listening. We will be reporting back to the Legislature on the issues that you've expressed. You've painted a really vivid picture of what's happening in your community.

I just wanted to know if your society has any peer support programs for those perhaps who have recovered or are moving towards recovery in terms of being able to counsel and to be kind of a friend to those in more acute situations?

1140

Mr. George Tucker: We don't have peer support per se, but we have support meetings and we do help when we can. People can call us on the schizophrenia line. One person calls as many as six to eight times a day. He is really struggling.

Ms. Helena Jaczek: So it's a volunteer position, manning the phone line?

Mr. George Tucker: In Thunder Bay we're all volunteers.

Ms. Helena Jaczek: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Sylvia, we've got about a minute left. Do you want to take it?

Ms. Sylvia Jones: Yes. Thank you, Mr. Tucker. A real fast question. Considering the role you're playing with the society, it may be an unfair one, but does the schizophrenia society in North Bay have a relationship with the John Howard Society? I'm interested because many of the examples you've used in your presentation had a justice component to them.

Mr. George Tucker: We don't really, but we will work together with anyone, and we have worked with other organizations in the past to help people with mental illness. We have gone to court on occasion to help people with mental illness and tried to keep them in the community and out of jail.

Ms. Sylvia Jones: Thank you for your presentation.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today, George. You did a wonderful job.

Mr. George Tucker: Thank you.

KINNA-AWEYA LEGAL CLINIC

The Chair (Mr. Kevin Daniel Flynn): Our last presentation of the morning is the Kinna-aweya Legal Clinic, Sarah Colquhoun. Is Sarah—I'm sorry. You're right in front of me.

Ms. Sarah Colquhoun: Yes, here I am.

The Chair (Mr. Kevin Daniel Flynn): I was looking in the audience. You've been here, I think, for a few of the presentations, so you understand everybody gets 20 minutes. You can use that any way, and if you leave some time at the end, that would be great.

Ms. Sarah Colquhoun: Thank you. You've been hearing and will be hearing from many health care providers about the lack of treatment in northern Ontario, and I'm sure throughout Ontario, and about innovative health care initiatives and ways to improve delivery of services in mental health and addictions treatment.

What I would like to speak to you about today is that many of the most important supports for people with mental health and addiction problems are not health programs. They are investments in affordable housing, income support and employment that promote full inclusion in our society. I know you've heard that, and I just heard George talk about the need for supported housing in the community. It's a key component to treating mental health and addiction problems and also to reducing the incidence of mental health and addiction problems.

Just by way of introduction, I'm one of the staff lawyers and the coordinator of legal services at the Kinna-aweya Legal Clinic. Our agency is a non-profit corporation that's funded by Legal Aid Ontario to provide poverty law services in the district of Thunder Bay. In addition to providing summary legal advice and

actual case representation for clients, we also have a mandate to do law reform work and provide public legal education.

The priorities that have been set by our board of directors in terms of the actual casework that we do focus on income maintenance issues and tenancy issues. "Income maintenance" is a term that includes all of the various income programs, such as Ontario Works and the Ontario disability support program, which are funded by the Ontario government, the Canada pension plan and employment insurance. All of the income support programs have appeal processes, and we help people do appeals if they have been denied assistance or aren't receiving what they should be.

We open somewhere around 600 files a year. We have contact with several thousand people in terms of summary advice and referrals. Most of our clients are on social assistance. Many of our clients have unsuccessfully applied for Ontario disability support program income support, and we assist them in appealing their cancellations. In the vast majority of those cases we are successful, which is financially very beneficial for clients because the amount that a single person receives on ODSP is almost twice as much money as they would be getting on Ontario Works. In the last few years, we've opened more than 200 files on that specific issue, and it's becoming an increasing amount of the caseload of all of the general service clinics in Ontario, to help people get on to ODSP.

We're successful in restoring or establishing entitlement to social assistance for hundreds of clients every year, but more and more we recognize that the biggest systemic issue with respect to social assistance is the inadequate level of benefits. We aren't able to provide specific statistics, but we know that the majority of our clients do have some kind of a disability, and most of our clients with a disability have some kind of mental health or addiction problem.

We're very pleased that the government is currently involved in efforts to establish a poverty reduction strategy, and we've been involved in that process over the last few years. People with serious mental health and addiction problems frequently experience barriers to securing adequate employment and education. They live in chronic poverty. I don't think anybody would question that. Living in poverty exacerbates mental health and addiction problems, so it's a circular kind of thing.

In our opinion, safe, secure and affordable housing is a key component to anyone's mental health. Not having enough money every month to pay the rent, pay the utility bills and buy groceries causes anxiety and depression. In our opinion, in many cases it would be better to treat that anxiety and depression by giving people enough money to pay the rent and buy groceries than with medication—or in addition.

I'd like to address several specific points with respect to the intersections between poverty reduction and the improvement of mental health and addiction services: inadequate social assistance benefits, discrimination

against disabled people with addiction issues in the ODSP, the need for continued funding for the addiction services initiative, the need for supported housing, and the need for improved accessibility to primary health care.

People on social assistance in Ontario don't get enough money every month to meet all of their basic needs. It's all very well to propose poverty reduction strategies that include employment programs and after-school programs, but they have to be combined with the basic issue of a significant increase in social assistance rates.

Just as an example, a single person on Ontario Works, which is the basic welfare program in Ontario now, receives \$216 a month for all of their basic needs other than shelter. So that's food, clothing, transportation, over-the-counter medication, everything: \$216 a month, and up to \$356 for shelter. So this single person gets \$572 a month for all of their needs, and it's just hopelessly inadequate. It's inadequate in Thunder Bay; it's inadequate in Toronto. There's nowhere in Ontario where you can live comfortably on \$572 a month. It's just not possible.

I'd like to give you a specific example of a client I recently opened a file for. She's a single woman who has been supporting herself in the workforce for 35 years. She's 50 years old. She has been working since she was 15, often at more than one job because she wasn't able to find full-time work. She had a long-term job with a large corporate employer that has a policy of not giving people more than 28 hours a week of work so that they don't have to pay benefits, and she had other jobs as well to supplement her income and had been supporting herself.

In the last few years, she's developed some serious health problems. They haven't been totally diagnosed. The neurologist thinks maybe it's multiple sclerosis, although usually that's diagnosed earlier. They don't really know what's wrong with her, but there's no question she has some serious health problems.

She has no health benefits. She used up her savings and she had to apply for Ontario Works assistance. She was referred by her caseworker at Ontario Works to the Ontario disability support program because they thought she should be on ODSP, but that application was denied, and that's what brought her into my office, to help her appeal that denial. That's going to take six to seven months to get through the appeal process. We have to obtain medical evidence and go through an appeal process.

In the meantime, she's getting \$572 a month from Ontario Works, which is the most that she can get. For the apartment where she has lived for 11 years, the rent is \$500 a month. That's cheap. That's well below the average cost of a one-bedroom apartment in Thunder Bay, which is almost \$700 a month. There's nowhere cheaper for her to move to, other than somewhere where—she can't imagine living in a room in a rundown rooming house or one of the motels on the strip that rents rooms by the month. Not surprisingly, the anxiety disorder that she has lived with for years and coped with while still

continuing to work and support herself has, in these circumstances, worsened. She's experiencing frequent panic attacks, and it's clear that the financial stress of being unemployed and not getting enough money to pay her rent and just live her life the way she wants to is causing the exacerbation of her mental health problems.

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Even if her ODSP appeal is successful and she moves to the much higher level of benefits from that program, it's still just over \$1,000 a month. She'll still be paying half of her income for rent. The maximum shelter amount is \$445 for a single person, so she's still going to be paying out of her basic needs amount for rent if she manages to hang onto that apartment over the next few months, which is questionable—whether she's going to be able to do that.

As part of the poverty reduction strategy meetings, a Liberal cabinet minister told me last year that the problem of poverty is complex—which I agree with; it is a very complex issue—but it cannot be solved by throwing money at it. My response was and is, how do we know? Nobody has tried solving the problem of poverty by throwing money at it. I'm absolutely, totally convinced, and I think you will find that there are many others who are convinced, that if benefits are increased to the level where people can pay their rent, buy groceries and pay their utility bills, that will solve many of the problems. There still will be problems, obviously, but giving people enough money to pay the rent and feed themselves and their kids would go a long way to solving the problems. They wouldn't have to use emergency utility funds, which are, half of the year, out of funds anyway. There wouldn't be as much use of food banks across the province, which has been skyrocketing. All of these programs are band-aid solutions to the fundamental, serious problem that our social assistance program does not provide adequate benefits to people. Clearly, it has an effect on people's mental health and also on addictions.

I saw an interesting film in Sault Ste. Marie last year that was done by a number of people in the homeless community in Sault Ste. Marie. I still remember this interview of a young woman, who'd been homeless, who said, "You know, people talk about the intersection between addictions and homelessness as if people are homeless because they have addiction problems." She's convinced from her personal experience of living on the streets that lots of people are having addiction problems because they're homeless. They're clearly interrelated.

I'm going to speak briefly about the issue of the need for adequate housing. I just want to speak about two specific issues. One is discrimination in the ODSP against people who are alcoholics or substance abusers. There's a section of the Ontario Disability Support Program Act that says that if a person with a disability is dependent on alcohol and that's the main reason for them being substantially restricted in their activities of daily living, they're not eligible for disability benefits. This has been challenged through the courts. It's been up to the Supreme Court of Canada, then back down to the Social

Benefits Tribunal, and then it was appealed to the Divisional Court. Litigation has been going on for about 10 years now, and at every single level, there's been a finding saying, "Yes, this contravenes the Ontario Human Rights Code. It's discrimination against people with alcoholism and substance abuse," which is recognized by the Ontario Human Rights Commission to be a disability, "and it should be stopped."

The Ontario government continues to appeal this. The Divisional Court decision that came out supporting the Social Benefits Tribunal decision, which just came out in January—the provincial government is now appealing that to the Court of Appeal. I think it's a waste of resources. It's a clear example of blatant discrimination against people with mental health and substance abuse problems. The government should stop discriminating against those with addiction problems in that disability program.

The addiction services initiative is a pilot project through the Ontario Works office, funded by the Ministry of Community and Social Services. Thunder Bay was one of the locations chosen for the pilot project. The project has been very successful. There are currently several hundred people in the project. They get additional supports. They've identified themselves that substance abuse is a barrier to them entering or re-entering the workforce. They get treatment, various additional financial supports and programming. The entire program is now in jeopardy. The ministry has said that they're not going to continue the funding for this program, which is very short-sighted.

Ironically, the existence of the addiction services initiative, even though it was only a pilot project in three municipalities, was one of the key arguments that the ministry used in justifying their discrimination against people with alcoholism in the Ontario disability support program. They said, "Oh, we don't need to put them into the ODSP and give them more money because there's this great addiction services initiative to help them," and now they're stopping funding for the addiction services initiative.

The need for safe, secure, affordable supported housing is a key component to anyone's mental health. All of us would be stressed and possibly depressed and anxious if we didn't feel that our housing was secure.

A single person on Ontario Works gets a maximum of \$356 for shelter if they pay for their own food. If they're in a room-and-board situation, they get \$450 a month. If that person is in an emergency shelter, the government provides \$1,200 a month for per diem payments. It doesn't make sense that you wouldn't give people more money so that they could pay for their own housing, instead of paying twice as much or three times as much to have them in an inadequate emergency shelter—not to cast any aspersions on the emergency shelters. I know people work hard and they're vitally important in our communities right now because of the lack of affordable housing, but that shouldn't be the primary choice for people.

If stable, affordable housing is provided to chronically homeless individuals with severe alcohol problems, the result is reduced alcohol use. There have been a number of programs, such as Housing First, where they'll take people off the streets and give them housing that's affordable, that they can maintain, and the results are very positive.

Independent housing with appropriate supports, if necessary, improves the quality of life and wellness of people with mental health and addiction problems, and it would take some of the pressure off the need for treatment if people were feeling better because they had better, secure housing and were able to maintain their housing. The need for supported housing is much higher than the supply, and the supply has to be increased with funding not just for the housing but also for the supports that are needed.

Just one final point on the need for primary health care: Many of our clients don't have a family doctor, which is the important entree into the health care system. You can't get into treatment programs and get in to see specialists and get medication if you don't have a family doctor or some other primary health care. There are thousands and thousands of people in the city of Thunder Bay who don't have family doctors or any entree into that and can't even get a proper diagnosis of their mental illness, let alone treatment.

In conclusion, I'd like to say that adequate income and affordable housing are key determinants of mental health and must be considered when you're considering development of a strategy to improve access to mental health and addictions treatment.

The Chair (Mr. Kevin Daniel Flynn): We definitely are hearing about the housing as we travel around just about everywhere in the province, so thanks for bringing that forward again.

We've got about three minutes left, so let's start on this side. Any questions?

Mrs. Liz Sandals: You mentioned the Housing First strategy. Do you want to talk a little bit about that? Is there a Housing First place in Thunder Bay?

Ms. Sarah Colquhoun: No. I'm just aware of it in other communities.

Mrs. Liz Sandals: Okay. Because that certainly is something that I've heard about in my community that people are trying to get started.

The Chair (Mr. Kevin Daniel Flynn): Sylvia?

Ms. Sylvia Jones: I have one quick question and then I'd like your thoughts on another. When is the pilot project for the addiction services initiative winding up?

Mr. Iain Angus: It has only been cut by a third and then it will continue. It's being spread across the whole province.

Ms. Sylvia Jones: Okay. My other question relates to the ability of individuals who are receiving ODSP to have part-time jobs. There have been a number of presenters who have concerns with the clawback, that it happens too quickly, that it's there at all. You haven't

raised that in your presentation, but I wondered if you had any thoughts on that.

Ms. Sarah Colquhoun: One of the things with the recent changes to that was they went to a straight 50%, so that 50% of your net earnings are deducted, which had more of a detrimental impact on people who were just working a small number of hours. There used to be a flat rate deduction, where nothing was deducted on the first \$160 that you earned, so people who were only working a little bit still had some benefit from their employment to help them. Really, you don't get enough money even on ODSP, which is a long-term program. For a single person, it's just over \$1,000 a month. So if you can earn a few hundred dollars a month, it's really helpful for people.

1200

Ms. Sylvia Jones: It seems to be yet another barrier to getting back into the workforce.

Ms. Sarah Colquhoun: Our focus recently has been on getting people into the program. There are lots of problems with the way the program is administered and how it works. Certainly, allowing people to keep more of the income that they earn while they're on the program would be helpful for them, I would agree.

The Chair (Mr. Kevin Daniel Flynn): The final question of the morning goes to Howard.

Mr. Howard Hampton: A two-part question: Is the housing problem getting better or worse in Thunder Bay, and are you seeing any supportive housing units?

Ms. Sarah Colquhoun: There are some supported housing units for mentally ill people with Alpha Court and a number of other agencies, but I don't think there have been any new units for some time—but that's not my area of expertise.

I do think it's getting worse, from our experience of the people who are coming in. The vacancy rate is going down in Thunder Bay, and certainly in terms of actual affordable housing for people who are on social assistance, it's very challenging for them to find housing. They also have issues with respect to things like George raised earlier: We have lots of clients who come in with notices of termination because of the way they've behaved and that kind of thing.

Mr. Howard Hampton: I have another question if I have time.

The Chair (Mr. Kevin Daniel Flynn): No, she answered both.

Unfortunately it's time for lunch, but I did want to thank you, Sarah, for being our last delegation of the morning. You did a great job. Thank you very much for being frank and forthright with us.

The committee recessed from 1202 to 1303.

The Chair (Mr. Kevin Daniel Flynn): If we can come to order, we can get back together after lunch now.

CHILDREN'S CENTRE THUNDER BAY

The Chair (Mr. Kevin Daniel Flynn): We've got the Children's Centre Thunder Bay with us: Tom Walters and Roy Karlstedt—obviously that's not true.

Ms. Jan Inkster: Not quite.

The Chair (Mr. Kevin Daniel Flynn): I'll let you guys introduce yourselves. You've got 20 minutes. You can use that any way you see fit, and if you could leave a little bit of time at the end, that always works better for some questions and answers. It's all yours.

Ms. Jan Inkster: No, I'm not Roy. I'm Jan Inkster, vice-president of the Children's Centre Thunder Bay board of directors. I'm an occupational therapist and a retired assistant administrator, having worked in mental health for 23 years. With me is Tom Walters, executive director of the Children's Centre Thunder Bay. He has been in that position for 21 years.

I'd just like to review the agenda for today. We've done our introduction. We're going to summarize the state of our children, the state of our children's delivery system, human resources, the hopes for the future, and a discussion.

The state of our children: Most of these statistics are from the National Institute of Mental Health in the US but have relevance for our province as well. One in five children has a diagnosable mental health issue, and this information comes from Dr. Dan Offord, from McMaster University in 1998; eight to 10 out of 100 children have anxiety disorders; six out of 100 children have major depression; five out of 100 have ADHD; five out of 100 children have learning disabilities; four to 10 out of 100 children have conduct disorders; one to three of every 100 children have bulimia.

Suicide is the second leading cause of death among 10- to 24-year-olds—and this comes from Stats Canada; seven to 14 children out of 10,000 exhibit autism spectrum disorder; and three out of 1,000 adolescents exhibit schizophrenia.

The state of our system: Our system is called the "orphan of the orphan." This was labelled by Senator Michael Kirby in the report *Out of the Shadows at Last*. It states that if the mental health system in Canada is the orphan of the health system, then children's mental health is the "orphan of the orphan." In 12 of the last 15 years, no funding increases have come to provincial community mental health centres. The Children's Centre in Thunder Bay cut 10% of its staff in 2003 and 2004, refocused the mandate to serving those most in need and cut out preventive initiatives. We refocused on short-term counselling to serve more families, but our wait list is currently 312, with clients waiting up to a year, depending on their severity of situation.

Community mental health centres are cutting or laying off staff while the demand for services increases. Other parts of the service system are calling for increased resources—schools, daycares, youth justice facilities, child welfare organizations, doctors and social service organizations—and yet we've had to cut and lay off. By inflation alone, the system lost 25% of its capacity. Schools, daycares, youth justice facilities, doctors, child welfare organizations etc. are calling for more service for children, increasing calls for more funding for mental health services.

The Auditor General, Jim McCarter, in 2009 also indicated that the estimated total economic cost attributable to mental illness in our province was \$22 billion a year when you include things like health care, law enforcement, motor vehicle accidents, crime and indirect costs resulting to lost productivity.

The review of the Roots of Youth Violence report, chaired by the honourable Roy McMurtry and Dr. Alvin Curling, was released on November 14, 2008. The report highlighted the need for more children's mental health services and recommended that an additional \$200 million be injected into the system to help deal with the roots of violence.

Mr. Tom Walters: I'd like to highlight for you some of the issues in relation to human resources in the children's mental health system. I think most of you are aware that there is a great competition for very skilled mental health clinicians or professionals, particularly in the arena of psychiatry, psychology and graduate-level social workers.

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Children's mental health centres in this province have fallen behind over the last few years in relation to the salaries they can pay compared to health or education. Just to give you an illustration of this, our centre, Children's Centre Thunder Bay, has lost five psychology staff in the last three years. We are currently still searching for more psychology staff. I think we have three vacancies and have not been able to find people to come to work with us at the salaries we pay. We've had no full-time child psychiatry for four years, and only sessional services available to us, but that's not always there either.

In the district of Thunder Bay, we have two child and adolescent psychiatrists who are currently working full-time, spreading themselves across a number of organizations. The Canadian Academy of Child and Adolescent Psychiatry standards suggest that our district should have nine child and adolescent psychiatrists. Their ratio is one psychiatrist for 4,000 youth, and we have about 35,000 youth in the district of Thunder Bay.

The other issue that is happening, which I believe serves as a barrier in relation to human resources and human resources initiatives, is that we have no coordinated HR plan across government bodies to help. In early June 2009, a group of service providers that I chair wrote to the Minister of Children and Youth Services, the Minister of Community Safety and Social Services, the Minister of Education, the Minister of Health and Long-Term Care and the chair of the North West LHIN explaining the serious issue we're having in relation to child and adolescent psychiatry. We asked for a meeting with these ministries. We pointed out that there was a need for leadership across government to help approach the problems and to work with us on trying to come up with a solution.

I think the responses were telling. The North West LHIN, in writing back to us, said it's "not our mandate." The Ministry of Education said they're working with MCYS and the Ministry of Health and Long-Term Care,

but their primary mandate is education. The Ministry of Community Safety and Social Services said that this "does not fall under this ministry." We've had no responses from either the Ministry of Children and Youth Services or the Ministry of Health and Long-Term Care. I think this makes the point that we really do need to have a better and more coordinated effort across this if we are really going to be able to provide the services that are required for children.

We do believe there are some hopes for the future. One of the things that I think the government has done that really stands out for me in the 21 years I've been a director of a children's mental health centre is that there now is actually a policy on children and youth mental health that was announced by the Ministry of Children and Youth Services in 2006. However, it's a policy, and not a lot of that has been implemented.

I think the new no-wrong-door initiative by the Ministry of Health is excellent. It cuts across all service systems in looking at ways to provide services to Ontarians, but there is a need to tie children's mental health into that, particularly as you look at transition-age youth who go from our system into the adult system.

I think this select committee is a hope for the future. I'm really looking forward to the recommendations you provide to the Legislature, and I hope that it will provide some leadership in addressing all the mental health issues in our province. The Canadian mental health commission, I think, is a breath of fresh air and is calling upon all provinces and our country to really come together and start to address issues of mental health across all age ranges.

One of my board members, who is a past president and is now president of our foundation, coined the phrase: "It is far easier to mend children than it is to fix broken adults." One of the travesties for me as a professional is to watch the number of children and families that come to us for help and our inability to actually provide them with timely help in a way that's going to address the needs they have when they come to our front door. If you have ever experienced emotional trauma in your family, you know that you need help with it now; you don't need help with it later. There are many, many promising best practices across the mental health field, not only in the adult sector but also in the children's sector, that prove we can actually help people very well if they get in for the help they need.

The last point I want to make with you is in relation to prevention. Jan mentioned to you that we had to cut back on a lot of the prevention work we were doing when we cut back as heavily as we had to on staff in 2003 and 2004. There is a best practice called Triple P parenting; you may or may not have heard of it. It is a practice that comes out of Australia and has 30 years of evidence-based research behind it. Many children's mental health centres and health centres are getting together and trying to implement this practice in our province. We believe that if you can help parents help children, you're going to multiply the effect of making our jobs easier, and then we

can deal more effectively with the ones who are most in need. But we really do need some kinds of preventive programs.

I call upon this committee to seriously consider making this a provincial program. Right now, it's piecemeal and is patched together by many children's mental health centres across the province, throwing extra money—a small amount of money for the Ministry of Children and Youth services. In our district, we have \$86,000 that came to us to start this initiative. I've dedicated an FTE to it. Other centres have done the same. We've got the district health unit working with us and doing some prevention on it. We're talking to schools about it; we're getting some support from them.

Manitoba adopted this as a provincial program, funded it and is coordinating it centrally. I believe that's something this province should seriously look at. If you want to address mental health issues, let's start earlier. Let's support parents in doing the things they need to for their children.

Those are our main points to you as a committee. Thank you for your interest, and we're open to any questions or comments you may have.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much, Tom and Jan. You've left about seven minutes for us to split up. Let's start with Sylvia.

Ms. Sylvia Jones: Thank you for appearing. I think you're the first children's centre. I've got a lot of questions, but I'll limit them to your human resource challenge. You mentioned that you have lost five staff.

Mr. Tom Walters: We've lost five psychologists in the last year.

Ms. Sylvia Jones: You may not be able to answer this, but are those five still in the field, just not with—

Mr. Tom Walters: I can answer that. All those five have stayed in the field, but they've moved into different sectors. One went into education, two went into health, one transferred to another children's mental health centre where they could get paid more and I think one retired.

Ms. Sylvia Jones: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Next is Howard.

Mr. Howard Hampton: I just want to be clear on this: By inflation alone, the system has lost 25% of its capacity?

Mr. Tom Walters: That's correct.

Mr. Howard Hampton: You're talking about your capacity here?

Mr. Tom Walters: The children's mental health sector in the province has lost 25% of its capacity to deliver service.

Mr. Howard Hampton: And what about in your case here?

Mr. Tom Walters: When we did our cuts in 2003 and 2004, we cut 10% of our overall staff. When you look at numbers, we're still serving the same number, but we're serving them in very, very different ways. We're providing a lot less intense or long-term service; we're providing a lot more short-term service. We started in a

walk-in counselling clinic in partnership with Thunder Bay Counselling Centre as a way to try to give better access to people, but we aren't able to take them into the longer-term kind of treatment they require. Other centres in the province have had to cut even deeper in terms of dealing with it.

Probably the biggest issues, in terms of inflationary costs, have been employee costs, insurance costs and those kinds of things. Those are the things that have been hitting us, and we just haven't had base budget increases to be able to address those.

Mr. Howard Hampton: You mentioned what Manitoba is doing in terms of helping parents. Can you describe that a bit?

Mr. Tom Walters: My understanding is that they have a central office that negotiates with the University of Queensland, where the program is housed. One of the biggest costs that I'm finding with the program is that they have all copyrighted material. What we've been doing is buying that copyrighted material, having them print it in Australia and it gets shipped here. The shipping costs and the cost to have it done in another country are absolutely bizarre.

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I think if we had everyone pulled together into a common group and we had one central point, we could negotiate a deal with those people to have ways of having it dealt with here, where we could still pay them for their copyright but we wouldn't have all the extra overhead and the administrative costs. Plus, if you can centralize it and have it as a provincial program, there will be a standardization of the way in which it is delivered across the province and it won't be piecemeal as it is right now.

My understanding is, that's what Manitoba has done. They've adopted it as a provincial program. They have a central office that coordinates it; they have mandated that all of their service providers will provide this; and they are working on developing five stages to this that go right from prevention on to dealing with very intense, difficult kinds of issues, which is primarily what we're focusing on—what they call a level 4 and 5.

That's what my hope would be for our province, that we could look at something like that.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Tom. Maria?

Mrs. Maria Van Bommel: I'm familiar, as the parliamentary assistant to the Minister of Children and Youth Services, with the Triple P program, but what I see of the Triple P is that it essentially teaches parents how to handle behaviour issues. I'm wondering how it actually helps parents, whose children have mental illness, identify and deal with mental illness issues. In some cases, the mental illness may manifest itself as a behavioural problem, but in other cases, you have a child who is particularly quiet and parents will congratulate themselves on having a very well-behaved child, not understanding that the child actually has mental illness.

Mr. Tom Walters: I don't think that what I'm proposing is that it would replace all kinds of parenting

education. What it does is it provides levels of skills for people.

You're right that it does focus a lot on behavioural kinds of things and out-of-control behaviour, so I think it's particularly applicable for children and families who are struggling with oppositional behaviour, struggling with conduct disorder kinds of issues, or just general strategies around how to discipline, how to communicate, how to deal with those kinds of things, all of which I think are good building blocks.

But if you had a child with a specific mental illness, you would have to have some additional support, I believe, in helping you understand the best way to approach that child to understand the symptoms and understand what they mean.

I don't see it as a total replacement, but I think it would be a far cry better for us to have a standardized program where we could help—because most people parent based on how they'd been parented. If they happen to have lucked out and had good parents, that's good. But if they haven't, they really don't understand how to parent the best way possible.

Mrs. Maria Van Bommel: Are you aware of any programs that would help on the mental health piece specifically?

Mr. Tom Walters: Our centre has taken the approach to work more on a self-help kind of prospect. For instance, we have parenting programs and groups for parents with autistic kids where we work specifically with them on how to deal with that kind of thing. I'm not sure that the Triple P parenting would be effective or recommended for that group.

We run specific programs for parents around dealing with teenagers, just as an example. Triple P could do that kind of work. If you're dealing with a depressed child, I think you would need other kinds of skills to look at drawing the child out and engaging the child, rather than just dealing with the kinds of things Triple P does. But I do think those kinds of things are available. We are looking for best practices all the time in terms of different approaches.

The Chair (Mr. Kevin Daniel Flynn): Thank you. That was good time management. Thank you very much for coming today, Tom and Jan.

Mr. Tom Walters: Thank you.

CATHERINE GILLIES

The Chair (Mr. Kevin Daniel Flynn): Any one of those microphones is fine, Catherine. You can sit anywhere you like. You can get set up while these guys are maybe unsettling themselves. There are some clean glasses there if you need any water for your presentation. Like everybody else this morning—now this afternoon—you get 20 minutes. You can use that any way you see fit. If you'd like to leave some time at the end, the committee would appreciate that.

Ms. Catherine Gillies: Okay. I'm here representing myself. I'm not representing any organization or group.

I'm here because I've struggled with mental illness my entire life, and I think it's important that people hear from us.

I don't think many people would know this about me, because I have lived a very productive life and I probably haven't exhibited a lot of my problems with mental health—at least, I don't believe so. I believe I've been pretty good about hiding it. But it's important that someone like myself becomes public about my personal issues with mental illness because I think that we need to de-stigmatize the whole issue of mental health and addictions.

A little bit about myself: I was born in 1949 and I was raised in a two-parent home. Both my parents worked hard their entire lives and have now passed away. I have two brothers, one older than me and one younger than me. I was destined to be the peacemaker in the family, the ultimate caregiver in my family, because I was the child of an alcoholic.

My father returned from the Second World War incredibly scarred by that experience and began drinking during the war. Alcohol was considered a reward if you were in the navy, which is what he was in. He was a gentle man and he worked hard his entire life on the railroad. He brought home his paycheque and then drank it away.

My mother was raised on the prairies and was one of 10 children and was the result of an arranged marriage—her parents' marriage was arranged. My mother struggled her entire life to keep our family together. She was a registered nurse and worked my entire childhood years and retired at the age of 65.

Both my parents have passed away, which is why I can give you a little bit of that background.

When I was 16 years old and in high school, I became depressed. I would go to school every day and I would cry. I was always an excellent student and I always got good marks. I was very quiet and didn't create any waves at school, but I was depressed. I was seen by a number of doctors, including a psychiatrist at the time, who said, "Make her go to school." So my mother made me go to school, but it didn't get any better for me and I continued to cry.

I took matters into my own hands and went to the local hospital and had them page the psychiatrist who had seen me. I told him, "I won't go to school. That isn't something I can do right now." He got me a position as a volunteer at that hospital. It was St. Joe's hospital at the time, in Thunder Bay. I worked in the rehab department, in the occupational therapy department, as a volunteer for the rest of the year. That was the beginning of my struggle with depression.

I returned to school in September of that year. I lost a year of school but I finished high school. I was an Ontario scholar. I went to university, got my degree in nursing and started my working life. I struggled with hospital nursing because I was always worried that I would harm my patients by making mistakes with medication. So I decided I would work in the community

and I did; I worked in public health, and my whole career was spent in public health.

The issues with medication were at the beginning of what I saw as my obsessive-compulsive disorder. In hindsight, I realized I had struggled with OCD for many years prior to that, but that was when I saw it exhibiting. The OCD that I have took many forms. I worried, when I visited newborns in their homes, that I would hurt them, so I developed my own strategies for making sure that I could have just one more look at that baby before I left them with their mum. I would drive around city blocks a number of times to make sure that I hadn't hit someone with the car, because I would not be able to bear it if someone had been hurt by something that I had done. I would open sealed envelopes to be sure I had put the correct papers inside before I could trust the item to be mailed. That's significant for me, because I worked in the genetic counselling program and we had many documents that were mailed and I made sure that they were correct.

I covered up my OCD and my depression through my whole working life and I don't believe that people would have known about those. I've been on antidepressants for many, many years and I don't think I will ever be off antidepressants, even though I'm now retired and supposedly my life is much more restful.

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The reason I feel that I can speak out now is because I'm no longer working—I'm retired—and so I don't believe that would be a concern for me, when it comes to an employer.

My life has had many ups and downs, as all our lives have had, but I have learned that admitting to depression has its own stereotypes. For example, I have recently been diagnosed with a non-malignant brain tumour and it's created many problems for me, particularly around short-term memory loss. When I went to the neurosurgeon—who happens to be in Toronto, since we don't really have someone who could deal with my problem here—to discuss the options that might be available to me, he gave me some information that I wasn't prepared to hear, so I started to cry, understandably. He looked at my chart, he saw that I was on antidepressants and he said to me, "Have you been seen by a psychiatrist?" I explained to him that I was upset with the information that he gave me and that was quite appropriate. It had nothing to do with my mental illness or anything else.

I guess I wish for the people of Ontario that mental health and addictions be taken out of the closet and talked about openly. I wish that instead of ostracizing those with mental illness and addictions, we see them the same way we see people with heart disease and cancer. We need to openly discuss these issues. My father was an alcoholic. He was sick. He had a disease. I suffer from depression and OCD. I have a disease. I've been treated and I'm no longer ashamed.

I believe I've lived a full life and have made many valuable contributions to my community. I sit on a number of boards and I have sat on a number of boards in

the past years. I believe there are many people who, like me, keep their illness a secret because of misunderstanding and prejudice. I believe there are many people who suffer in silence rather than admit they have a mental health problem.

I have some suggestions, and you'll have to bear with me. Because my background is in public health, I like to look at stopping people from falling into the water rather than pulling them out of the water downstream.

My first suggestion is to look at the Roots of Empathy program. If you don't know what Roots of Empathy is, its mission is to build caring, peaceful and civil societies through the development of empathy in children and adults. That helps all children to learn about empathy and inclusion, therefore removing the stigma of differences. I've been on the committee that brought Roots of Empathy to Thunder Bay and I am a true believer in that kind of intervention at the very start.

I think we should be incorporating mental health and additions strategies in the Ontario public health standards since prevention and screening are less expensive both financially and socially than treatment. In the public health standards, the ones that are mandated by the government, there is a portion called prevention of injury and substance misuse, but that's way too small a component of prevention strategies.

I think we should make mental health and additions a standard curriculum in all high schools, colleges and universities so that individuals understand what mental health and additions are and they're talked about as a health care issue or as a part of health.

I think we should develop programs for physicians, nurses, police officers, paramedics and other front-line workers that make them sensitive to issues of mental health and additions. I think we should develop programs in community health centres that would target street people, homeless and underserved individuals in order to create novel entry points into the system.

An idea that I've had and I've thought was something that we could consider is to provide veterinary services for the pets of low-income or street people, many of whom have pets because that's the only thing that loves them unconditionally. They would give up the food that they have and the care that they need in order to feed those pets. And it would help establish a trust relationship with care providers, using that venue to bring them into care settings.

I think we should be creating resources for physicians that would help them to work with patients who have become drug-dependent because of illness or injury. I know a lot of people who have become addicted through the need for pain medication and whose physicians don't know what to do with them. I think we should have the Workplace Safety and Insurance Board include additions in their workplace disease category since many people develop additions because of workplace injury.

I think we should have electronic health records for all of Ontario in order to allow consistency in the management of mental health and additions and prevent over-medication and mismanagement of all health issues.

Finally, we must take away the shame and the stigma of mental health and additions and openly view good mental health as a goal for all citizens to have. We must stop punishing those who are ill and struggling. We must be more inclusive. The silence surrounding mental health and additions creates problems for individuals, families, schools and employers. We need programs that will help individuals to be understood and support them as they recover.

Imagine going for help to the emergency department of your local hospital and being treated with derision, ignorance and distaste. Never forget that feeling as you make your recommendations for changes to the system. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Very good. Thank you, Catherine. You've left six minutes for some questions. We're going to start with Howard. We'll get about two minutes each.

Mr. Howard Hampton: Thank you for a lengthy list of recommendations. Since your area of expertise is public health, of the things you talk about, how many of those things are being done now, in your experience?

Ms. Catherine Gillies: Of the things that I talked about, very little. Roots of Empathy, for one, is a very expensive program. There are a few programs available, one of which is out of NorWest Community Health Centres—Wendy Talbot is here—and a few other places, but it's not universal. It's a very expensive program and it needs to be universally funded in order for it to be provided in every school in the province of Ontario.

I saw from the listing you're going to be getting a presentation from somebody from the Drug Awareness Committee of Thunder Bay—I was on that committee at one point, too—and they can talk a little bit about what they're doing, but there aren't a lot of programs that would be available provincially and standardized, for example, in every educational setting to be able to provide that information. The WSIB I know because I did a project out of NorWest Community Health Centres funded by WSIB. It's certainly not open to anything to do with additions as part of their system at all.

I know electronic health records has just been—

Mr. Howard Hampton: It's been in the news.

Ms. Catherine Gillies: —in the news, but I also know that if you can't doctor-shop, if you have something that allows the care provider to know exactly where you are, that can help in many ways.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Catherine. We'll move on. Liz?

Mrs. Liz Sandals: Thank you so much for sharing your experience with us. I've got two questions. One is a public-health-experience-related one: If you were going to put out information about mental health and addiction and beef that up in the provincial curriculum, what sorts of information would you include for kids?

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Ms. Catherine Gillies: For kids? Or for anyone—

Mrs. Liz Sandals: Well, or a range of ages.

Ms. Catherine Gillies: I mean, that's a huge—

Mrs. Liz Sandals: It's a huge topic.

Ms. Catherine Gillies: What can I tell you? It's huge, and better people than I would be able to give you specifics on that. But in the old days, when I first started in public health, we used to do a lot of home visiting with seniors, for example, or with people who might have been discharged from a hospital setting and who had some mental health issues. We didn't have a lot of rules that we had to follow that the government had put upon us. So we did a lot of that kind of visiting.

I'll give you one quick, quick example. I received a call—I was on what was called phone duty—from a person in an apartment block who was concerned about an elderly couple in that building. She just didn't want to give me her name but she was worried about them.

I went over to that building and knocked on the door and I said, "I'm just a public health nurse. I was just in the building and I wondered how you were doing." As it turned out, the husband had severe dementia that had been unrecognized and untreated. The wife was coping as best she could. Through building trust, we, meaning public health nursing, could get assistance for that individual.

That isn't in there any more. Public health doesn't have that mandate any more; the mandates are very specific. They've lost those community connections, and nobody has taken those connections up. So that's just one.

Mrs. Liz Sandals: And then the other is a more personal question, and it's up to you whether you want to answer or not. You've obviously dealt with your mental illnesses very successfully and had a wonderful life and contributed a lot to the community. Can you identify something that enabled you to cope?

Ms. Catherine Gillies: Irish stubbornness.

Laughter.

Mrs. Liz Sandals: I think that's a lot like Scottish Presbyterian stubbornness, which I also claim.

Ms. Catherine Gillies: I think I can say I've been lucky. I married a wonderful man who was very accepting and supportive of me. I've just been lucky, yes.

The Chair (Mr. Kevin Daniel Flynn): Okay. Thank you, Catherine. Sylvia?

Ms. Sylvia Jones: One question, to tie back into your suggestion about electronic health records: A recurring theme that we're hearing a lot is that many people who have mental health illnesses are not getting access to family docs, which of course is the door to every other service. Do you believe that putting the electronic health records in place would give the family physicians a comfort level?

Ms. Catherine Gillies: It might. I guess I've been very fortunate to have the same family physician for many years, who is probably going to retire soon, and I will be without a physician. I don't know what I'll do then.

I think that electronic health records certainly give a bit more control and the ability to monitor a patient a lot better. Maybe that would help; I have no idea. I have a

whole lot of suggestions around physicians, but that's for some other venue than this.

I don't honestly know if that would make them more comfortable. I think they need resources to make them more comfortable. I think they need to be able to know that they can give a particular client over to somebody who has expertise, who would support that client through whatever the issues are, but it's not there. Like I say, everybody who has presented is pulling the person out of the water at the end of the stream rather than keeping them from falling in, at least in today's sessions that I've listened to.

The Chair (Mr. Kevin Daniel Flynn): Thank you for coming today, Catherine, and for telling your story. It was really appreciated.

Ms. Catherine Gillies: You're welcome. I hope it was helpful.

The Chair (Mr. Kevin Daniel Flynn): It was very helpful. Thank you.

ADVISORY COMMITTEE FOR MENTAL HEALTH AND ADDICTION SERVICES

The Chair (Mr. Kevin Daniel Flynn): The next person we have coming forward is Keith Zehr from the Advisory Committee for Mental Health and Addiction Services. Keith, thank you for coming.

Mr. Keith Zehr: Thank you. I first met Catherine about 48 minutes ago, and—

Interjection: She has that effect.

Mr. Keith Zehr: —if it weren't for probably the wrath of the rest of my advisory committee members, I think I'd allot the next 20 minutes to her.

Actually, to that end, I'm going to start with the last statement I was going to make in this presentation. I'd like to ask that you do one thing during your consultation, and that is to take some time to have a meaningful conversation with a person who has a mental illness or an addiction. Don't just listen to the person's speech, but truly engage with the person as you would with a colleague or a friend. I guarantee this one conversation will have a lasting impression. It has on me inside of that four or five minutes when we were actually having some dialogue about the personal issues beyond even the public health professional career, but also who you are as a person and how it is that you got to where you are in what would seem like such a successful manner. Thank you, Catherine.

Thanks a lot for allowing me to be here and to speak on behalf of the Advisory Committee for Mental Health and Addiction Services here in Thunder Bay. My name is Keith. I'm a member of this committee that provides advice to three health care boards of directors: Children's Centre Thunder Bay—you've heard from Tom—a children's mental health centre or agency; St. Joseph's Care Group, a multi-site, non-acute health care corporation that provides long-term care and physical rehabilitation services along with in-patient, outpatient and outreach mental health and addiction services; as well as

Thunder Bay Counselling Centre, a community agency focused on supporting individuals and their families.

Our agencies provide comprehensive clinical and support services for children, adults, seniors, and family members/natural supports through the continuum of care. We work in concert with numerous other mental health, addiction and health care agencies in the communities throughout our region.

Our mandate as an advisory committee is to keep the three boards apprised of emerging mental health and addiction service issues throughout Ontario and our region. Actually, it's really cool: I want to highlight the fact that it truly is three boards. This is one advisory committee that is accountable to and responding to the needs of three separate agencies and three separate boards. I think their foresight and their vision—if not, quite frankly, the realities of having dearths of services and people to be able to fulfill roles—resulted in some pretty creative collaboration for us to be able to come together as an advisory committee for three.

We also look at what are the emerging mental health and addiction service issues throughout Ontario, to support the boards in systemic change and potential strategies to advocate for system improvement; promote public awareness and address issues of stigma and discrimination; and support collaboration and partnerships with all health care, human services, youth justice, adult justice and social service providers.

The members of our committee are consumers and family members as well as representatives from mental health and addiction agencies, social service agencies, police, justice services and the general public. My day job is as executive director for Creighton Youth Services. We provide custodial and alternative-to-custody programs for—we still call them young offenders. I joined up 29 years ago, when it was under the JDA, and I worked at a training school, and it seems like “young offenders,” even if they aren't part of the parlance of the YCJA, still seems to work. One would be too many, but sadly, our youth justice experience is, I believe, a replication of what we're seeing in the adult system. With kids, I see it as particularly tragic in that one would be too many, but we see many, many, many youth who are in custody not because they have criminogenic factors or needs, but because they have mental health issues that are not addressed otherwise. We are criminalizing our kids for having mental health issues, in my experience.

Although we all come to the table with different life experiences, we all have a clear vision about the future. We believe that some day, people with mental illness and addiction issues will be accepted into our neighbourhoods and communities without scorn, ridicule or discrimination. We believe access to mental health and addiction treatment will match access to other health care services, as Catherine talked about. We believe the overall health and well-being of our target group will improve considerably and be equal to that of the general population. And, finally, we believe families and care-

givers will no longer be embarrassed to talk about their family member who is living with a mental health issue and/or an addiction.

In our opinion, it's important for all of us to shift our thinking about mental illness and substance abuse. We need to acknowledge and accept that people with a mental illness and/or substance abuse issue did not choose the illness. They can't easily treat themselves or just “snap out of it.” We need to embrace the concept of recovery and hope, and to celebrate, with our community members, every step in the journey of healing. We must open our hearts and our minds, because the person with the mental illness and substance abuse issue could be your daughter, your father, your spouse, your co-worker or your friend. It could be me; it could be you. We heard it was Catherine.

The statistics, as you're aware, are staggering. We've read it in the discussion paper, but I feel it's worth pointing out again: 20% of Ontarians will experience a mental illness in their lifetime. Rates of depression and other mental illnesses now exceed rates of cardiovascular disease. In the three years since I joined Creighton Youth Services as executive director, I personally know of seven youth who have been in our care who, when they returned to their home communities, chose to take their lives.

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Mental illness is the biggest cause of workplace absenteeism. One out of every 10 Canadians aged 15 years and older reported symptoms which indicated alcohol or illicit drug dependence in 2002 to 2003. Also in that spread, Ontario hospitals provided almost 1.5 million days of mental health and addiction treatment, with one third provided by acute care facilities, and two thirds by specialty facilities.

The waiting lists for treatment for mental illness are increasing in Ontario. Last year in Ontario, people seeking mental health services waited approximately seven weeks to see a specialist and another 10 weeks for treatment to begin. One of our mental health programs is now receiving over 200 new referrals each month. It suggests some success and awareness and “Let's seek some help.” Sadly, the wait time to access specialized mental health care is 10 months. Do the math. People requiring counselling in a shared mental health care setting must wait four months, yet research shows that people with mental illness should wait no more than two weeks to access services.

I feel like I've missed an opportunity on behalf of youth justice to not have gotten 20 minutes for that—but the advisory committee picked me. With respect to some of the youth justice issues as I've already identified and will build on now with respect to access to services, we have kids here in Thunder Bay who would be best suited in what is known as a secure treatment designated facility. We have two in Ontario: One is in Ottawa and one is just outside of Toronto. We have kids here who have been told that they are too difficult for those programs.

The economic costs of mental illness and addictions are approximately \$34 billion a year, including health care treatment, law enforcement and workplace absenteeism. However, many families will tell you that the costs of addiction and mental illness are far more than just economic. Sadly, people with mental illness and/or addiction issues have learned to accept stigma and discrimination as their reality and to hide their problems. This makes it even more difficult to provide appropriate services.

So what can we do to improve the system of care? First and foremost, we believe in working in partnership, as we've tried to exhibit in our collaborative fashion specific to this committee and in other areas across Thunder Bay and northwestern Ontario where, again, sometimes it's as a result of not having the resources that we are forced into the potentially, I suppose, counter-intuitive reality of needing to work together and therefore creating some collaborative efforts.

We believe that, first and foremost, funders, providers and policy-makers within Ontario's health care system and the social service and justice systems must work together to achieve a comprehensive continuum of care and service that is accessible, welcoming and based on best practices. Every door, in my opinion, might be the right door; I wish there was one and it was never locked.

Many of our current services are structured in silos that match the source of funding, including the various provincial ministries—health, children and youth services, community and social services, housing, and community safety and corrections, for example—as well as federal and municipal bodies. Consumers and family members are truly not concerned about the source of funding; they just want help.

We appreciate, in the discussion paper, that the transformation expectations discussed are pushing toward some of the things that I have talked about, in terms of rectification, and that I will offer as potential solutions. Our concern is that, without an extremely solidified, considered coordination and funding source that isn't siloed and isn't parsed out and isn't a part of somebody else's bailiwick rather than the main one, even the least of the recommendations might never see fruition. We see an incredible need for a dedicated and specific single source for coordination and funding.

We believe, for access, that clients must have access to the appropriate level of care in a timely manner. Access to services must be equitable. Social-economic status, culture and geography should not influence the type of care a person receives or the length of time it takes to receive these services. At the point in time when an individual has mustered up enough courage to walk into an addiction treatment centre or has decompensated enough to be taken to the emergency department, he or she should not be told that there's a six-month waiting list to see the appropriate health care provider, in our opinion. The system should have sufficient capacity to meet people's needs in a timely manner.

Integration: Mental health and addiction services should be part of the fabric of the health care, social and

justice service systems. Health care and social service providers oftentimes work in isolation from mental health and addiction care providers, even though they are working with the same individuals.

Back to my little side agenda here: We see it in children and youth services. We were very, very, very happy to have a brand new ministry, only to see youth justice have a bigger silo than we used to have under ComSoc days. We work at it. We try and help our colleagues in the public service and governments to figure out ways of doing it. My experience is that it is very difficult to open and keep open the doors of silos rather than not building them or reinforcing them at all.

All providers, we believe, must identify the resources that are needed by the target group and work in an integrated and collaborative manner that is invisible to the people served. It doesn't matter to them. Sometimes we think we should have a guide to help people through the system. It sounds great until you realize if we had a system that didn't need a guide, wouldn't that be a whole lot better? In our opinion, funders, policy-makers and service providers all need to let go of their own turf and dismantle the silos. Leadership across ministries is required to set the stage for integration and the development of a system that meets the needs of all Ontarians, in our opinion.

Consumer voice: Consumers and family members must participate fully and have a strong voice in planning and decision-making, not only in meetings about their own care, but in system planning and design forums—we appreciate that that opportunity has been provided here—and would also look at any next stages such as figuring out if there are systemic barriers to even those who might be willing to speak to youth, to not exactly knowing how, or could they afford the call to Toronto to do it, if they weren't aware there was an 1-800 number.

For decades, health care providers have planned and established systems of care based on what they believe to be best for the people they serve. But the best care system truly is one that is designed with the full participation, in our opinion and experience, of the people receiving the care and their family members and natural supports. Consumers have clearly stated that the invitation to participate must be genuine and not an afterthought, when the majority of the planning has been completed.

Cultural sensitivity: The diverse needs of the population of northwestern Ontario must be addressed. It is estimated that in 10 years, between 35% and 45% of the population of Thunder Bay will be aboriginal. Although care providers are aware of the need to be culturally sensitive, we don't always fully understand or appreciate the social, political, language and spiritual needs of the people with whom we work, nor do we consistently practise in ways that will support them in a caring and respectful manner. We need to ensure that all people, regardless of age, language, gender, race, sexual orientation and geographic origin, feel welcomed into the system of care and fully supported during their journey of recovery.

Research and best practices: We believe that this information must be transferred into practice in a timely manner. It has been estimated that it could take up to 15 years to translate gains in knowledge into clinical practice. Aggressive efforts, in our opinion, must be made to significantly reduce this knowledge transfer time gap. People with a mental illness or a substance abuse issue deserve services and care based on the best available knowledge and scientific evidence as much as the person with cancer or cardiac issues.

Safe, affordable housing with supports: Supportive housing is a key component of a well-designed mental health and addiction treatment system. At this time, almost 50% of in-patients in Lakehead Psychiatric Hospital meet the criteria for long-term care or supportive housing. Due to financial constraints and restraints, insufficient capacity in the long-term-care sector, and lack of sufficient supportive housing resources, many people must remain in-patients of mental health facilities when that level of resource is no longer required. Many people with a mental illness or substance abuse issue and their families live in deplorable housing conditions, if not on the street. How can we expect them to even begin a journey of recovery if their basic needs are not being met? How can we expect them to have hope?

More resources, in our opinion, must be directed to establish safe and affordable housing with necessary supports to provide stability and safety and give them the opportunity to begin their journey. Long-term-care facilities must be funded appropriately to accommodate seniors with mental health issues.

In summary, we believe there is so much that must be done to improve the health care and social service system to better meet the needs of people living with mental health and/or addiction issues and their family members.

We thank you as a committee and I thank you personally for providing the people of Ontario with the opportunity to engage with you and to share their perspectives and priorities. We are hopeful that changes in the system will be positive and we look forward to being part of that changing system.

And I end where I started. I met Catherine about an hour ago. Thank you, Catherine, for sharing.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Keith. We appreciate your presentation. You've left about four and a half minutes, so if we make them quick, Helena, we can get three questions and answers in.

Ms. Helena Jaczek: Thank you very much, Keith. I really don't have a question about what you've presented, because it's so comprehensive and understandable. But we have heard quite a bit about peer support as we've travelled around and I was wondering if you have any specific recommendations about what that would really look like. We know we want people with mental illness to have a home, a job and a friend, and that friend piece can often be a peer. Do you have services in Thunder Bay that could be described as peer support? Do you have ideas for improvement?

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Mr. Keith Zehr: If there are services beyond some of the high school-implemented peer-to-peer counselling services, I'm not aware of them. I would defer, if it's okay—if Tom's still here—to Tom or to Wendy Talbot, who might have better ideas about it. Do you, Tom, in terms of what's available, or any recommendations?

Mr. Tom Walters: There certainly are some peer-to-peer support groups, some consumer-led initiatives. They certainly contribute tremendously to people feeling that there's someone who'll listen to them who has the same kinds of problems.

I had the opportunity a number of years ago to sit on the planning committee for mental health for this region, and there was a strong consumer contingent on that group who really, really kept pushing the need for consumer and family involvement. I think it's a direction that should be looked at very carefully.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Tom.

Ms. Wendy Talbot: Since Keith asked me to come up—and I'll speak really quickly—the one population that that doesn't apply to is the population on the street. They're more interested in eating than peer counselling. So let's remember that group, and it's huge.

The Chair (Mr. Kevin Daniel Flynn): Sylvia?

Ms. Sylvia Jones: I wanted to get further into your consumer voice, where you say, "Family members must participate fully and have a strong voice in planning and decision-making"—again, something that we have heard consistently. What we haven't got—and I'm wondering if your committee delved into it further—is how you balance the privacy rights of the individual against the desire of family to be part of the healing process.

Mr. Keith Zehr: In a bit I'll defer to Tom again, but in my experience families don't really care a whole lot about the privacy issues when it comes to whether they're going to be helping the system; it's more, "What are the legal issues that we're caught up with?" So—I should stop before I—

Ms. Sylvia Jones: I agree, but the law does, right?

Mr. Keith Zehr: Yeah.

Ms. Sylvia Jones: I mean, the law is very specific about what can be shared with the families and what can't. So I wondered if your committee had figured out how to deal with that.

Mr. Tom Walters: I don't think we have any golden answers for you on this one. I agree with you: It's a very complex issue. The only thing I can suggest to you is that when families say that they want to have a voice, I think their voice should be used in relation to the kinds of services that are required, rather than focusing on the individual care of their own relative. That's where you get into the confidentiality and privacy issues.

We run into the same thing with youth in our own children's system, where youth over the age of 12 can come to our centre and have services without their parents' knowledge. Now, certainly, we encourage them—and I would say 99% of them agree—to have that

information shared. With young adults that becomes, I think, a little more tricky, because sometimes they want their own privacy.

So the weight, I believe, to engage families is to really engage them in some planning of services and help them provide their perspective on what would be supportive, not only to them but to their loved ones. But you can't allow them to delve into the individual issues. You have to keep that screen up.

The Chair (Mr. Kevin Daniel Flynn): Okay, thank you, Tom. Howard? There's about a minute and a half left.

Mr. Howard Hampton: You deal a lot with work in partnership and integration, and you identify the problem of silos. I wonder if you could outline for us how you think integration and work in partnership should be achieved, because I think Cathy tried to answer the question. What I got from her is that she feels very strongly that the community mental health centre or public health could provide that integrating opportunity to do this.

There are a couple of places around the province where you have what are essentially community health centres and multi-service agencies, where you have nurses, social workers, psychologists, psychiatrists, nutritionists, physicians and educators all working out of the same building. Do you have any suggestions for us? Not only working out of the same building; they combine funding from various agencies. I'm told that people in the community feel they do an excellent job.

Mr. Keith Zehr: I'm going to defer to Wendy in about 30 seconds, but with respect—

The Chair (Mr. Kevin Daniel Flynn): I don't think we have 30 seconds.

Mr. Keith Zehr: We don't have 30 seconds?

The Chair (Mr. Kevin Daniel Flynn): You've got to handle this solo.

Mr. Keith Zehr: Okay. Then it might not be so much advisory as my own personal experience, and that is with incredible respect. I have colleagues who operate organizations that have children's mental health, child welfare and youth justice and they have three separate program supervisors from the same ministry that they're dealing with. That, for example, to me would be one way of starting to break down silos even within our funding ministry, to be able to have people talking to each other rather than, even inside, the divide-and-conquer mentality that people have to work really hard at not getting in the way.

The Chair (Mr. Kevin Daniel Flynn): Okay. Thank you very much for coming, Keith. We appreciate it.

DISTRICT OF THUNDER BAY SOCIAL SERVICES ADMINISTRATION BOARD

The Chair (Mr. Kevin Daniel Flynn): Iain and Joe, if you'd come forward and make yourselves comfortable and introduce your third partner, whose name I don't have.

Mr. Iain Angus: Thank you, Mr. Chairman.

The Chair (Mr. Kevin Daniel Flynn): You've heard the spiel?

Mr. Iain Angus: I've heard the spiel a number of times over many years.

Mr. Chairman, members of the select committee, first let me thank you for conducting these hearings here in Thunder Bay so that the people of this region have an opportunity for input. The northwest is indeed different from other parts of Ontario, with mental health issues having their own story and perhaps their own solution.

With me today is my fellow municipal councillor, Joe Virdiramo, not only representing the city of Thunder Bay, but he's also the child advocate for the city of Thunder Bay; and our CAO of the District of Thunder Bay Social Services Administration Board—and that's the last time I'm going to say that—Mary Lucas. Our vice-chair, Elaine Mannisto, from the municipality of Greenstone, was unable to join with us today due to a prior commitment.

Mr. Chairman, we've reviewed the Ministry of Health and Long-Term Care consultation paper, Every Door is the Right Door, and wish to commend your government on the release of the consultation paper. It said a lot of the things that we've been saying as an organization. We are also very pleased to see two representatives from our community on the advisory committee: Nancy Black, director of community, mental health and addiction services, and Dr. Ty Turner, chief of psychiatry.

As you may be aware, TBDSSAB is responsible for the funding, management and delivery of child care, social housing and Ontario Works in the district of Thunder Bay. Just so that you're clear, there are two other districts, the district of Rainy River and the district of Kenora. We have no jurisdiction there. It's just the district of Thunder Bay. Our clients are the most vulnerable members of society, and all three of our portfolios have a relationship with and impact on the mental health of our communities and the people who live there.

Our board and our staff have long been concerned about the welfare of all of the people who rely on our organization for support. We view it as our responsibility to take a holistic approach to meeting our clients' often complex needs. In more recent years, the issue of obtaining supports for people with mental health concerns has become a focal point of concern for us.

A 2004 housing needs study prepared for the TBDSSAB by the Thunder Bay District Housing Corp. found that our waiting lists for seniors' housing had all but disappeared, our waiting lists for families had reached a more manageable level, but that the emerging issue for us was the provision of accommodation for individuals who required varying degrees of supports throughout the day and night. That same report also identified the challenge that while funding for the bricks and mortar came through the Ministry of Municipal Affairs and Housing, with a very significant contribution from the property taxpayer, which continues today, fund-

ing for supports comes from other ministries, mainly the Ministry of Health, and now through the LHINs.

Difficulties that our clients, service providers and staff encounter in accessing mental health services in our district were also formally raised to TBDSSAB by a deputation of concerned citizens back in June 2003, and our staff have also identified numerous concerns related to helping clients access appropriate mental health treatment.

Many of our concerns today echo the original worries about deinstitutionalization. As an MPP from 1975 to 1977, when all of this started, I remember well the concerns that were raised when the Ontario government announced that it would be moving people out of the psychiatric hospitals into the community. At that time we, the opposition parties and the communities, stated categorically that the community supports had to be in place before the shifting occurred. That did not happen.

In response to these ongoing concerns, our organization completed a report and environmental scan in late 2008 assessing the impact of mental health system reform activities on social service clients. Our report found that difficulties accessing mental health treatment and supports seemed to be continuing, notwithstanding many recent major mental health system reform plans, activities and improvements to treatment such as new medications.

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In order to illustrate just some of these access issues, we would like to share with the committee some of the results of psychological tests completed on our clients over the last several years.

We have found that many of our clients in the Ontario Works program have previously undiagnosed, untreated and apparently unsupported mental health problems as well as intellectual and learning disabilities. We have discovered these conditions by paying for psychological assessments, not available from the mental health system, for some clients who we believe may be unable to participate in our programs and/or maintain their independence.

Some of the findings of a sample of 378 psychological assessments completed between January 2004 and June 2008 include:

- 231 of the 378, or 61%, were diagnosed with psychological disorders ranging from borderline personality disorder to major depression and schizophrenia.

- Approximately 27% assessed were found to have intellectual disabilities and/or were diagnosed with global intellectual and developmental disability, or mental retardation, but were nonetheless trying to participate in the Ontario Works program independently, without any community supports we were aware of.

- Approximately 32% were found to have learning disabilities such as attention deficit hyperactivity disorder, disorder of reading, disorder of written expression, or visual and math deficits.

- Numerous clients were identified as functionally or totally illiterate—not evaluated in all assessments.

- 27% were diagnosed with substance abuse problems, typically severe or chronic.

- The average age of the individuals assessed is 39 years, so these were not new problems but were nonetheless untreated and unsupported.

- Upon completion of the ODSP disability application process, 83% of the applicants have been awarded provincial disability supports, meaning that their disabilities were confirmed to be quite serious, limiting the ability of these clients to independently seek and maintain employment, not just for today but for the long term.

The vast majority of these clients were previously undiagnosed and untreated for these disorders and were receiving no community supports that we are aware of. The fact that these individuals were attempting to independently participate in the Ontario Works program in spite of their serious disabilities indicates that they are, and have been, inadequately supported in the community. What is amazing is that they were able to get through the intake process that the province requires of them.

As Minister Matthews has pointed out herself in her own report, the application system is not designed to be a supportive and client-friendly process, especially for those with any type of disability. How can we expect someone who is bipolar or clinically depressed, who has difficulty getting out of bed many days, to spend the time trying to get through the process of applying for Ontario Works or ODSP, let alone to seek help for the pain they are enduring?

In addition to paying for testing, TBDSSAB has also hired a dedicated intensive-case manager to assist clients with the application and participation requirements of Ontario Works as well as to help them obtain treatment.

Many of these clients were referred for psychological testing from our Ontario Works addiction services initiative, or ASI. It is well known that the issues of substance abuse and mental health are inseparable, and our experience has confirmed this.

We wish to point out and to confirm what I said to you from the back of the room this morning: The province has expressed an intention to cut the funding for the Thunder Bay ASI program by almost one third by 2011. We feel that this cutback is particularly inappropriate, given the increasing prevalence of substance abuse in our district and the lack of supports that are available for our clients elsewhere in the system. We do, however, welcome the decision of the government to expand the program to areas in the province other than the pilot areas like Thunder Bay, but believe it inappropriate to do it by taking some of the funding from our program.

In the area of social housing, interviews with our housing providers indicated growing concerns with tenants who seem to have inadequately treated mental health and addiction problems. The behaviour of many of these tenants has led to their eviction from social housing, as housing providers are not adequately prepared to cope with these behaviours without outside assistance—and I'd like to add private sector housing as

well. It's not just social housing that they get evicted from.

Our largest provider, the Thunder Bay District Housing Corp., with a portfolio of 2,520 units, has only two community resource workers who are able to assist the tenants in getting the supports they need. They report extreme difficulty and a lack of response from the mental health system when they attempt to obtain assistance for the tenants. These are often the 2 a.m. phone calls that a property manager has to make.

Often, disruptive tenants are taken away by police and returned to their apartment the same night with no apparent treatment or follow-up from the mental health system. In some cases, tenants must be restrained, handcuffed and forcibly removed by the police only to be discharged from hospital a short time later, often becoming unstable again in a short time.

Those who are evicted due to their behaviour or for health and safety concerns, such as the fire risk that hoarding represents, are then forced to rely on Shelter House, our local shelter, which TBDSSAB partially funds through the per diem system of payment. Shelter House then works—and they do a very good job of this—with the clients and assists them in finding mainstream housing. They get them some supports for some time and then the cycle starts all over again. It would be better if there was a supportive housing facility in which we could house them so that they could get the assistance they need to remain healthy and secure.

In addition—and this is not just a Thunder Bay problem—we are receiving requests from community agencies, as well as smaller communities in the district, for supportive housing. For example, we're working currently with St. Joseph's Care Group to convert some of our existing units to supportive housing. We have the bricks and mortar. We don't have the supports. There is tremendous concern in our communities regarding appropriate supportive housing and the ability of citizens to survive in smaller communities.

We interviewed the Thunder Bay Police Service as part of our environmental scan, and they reinforce our concern that there are apparently many individuals with serious, inadequately managed mental health problems living in the community, and it is difficult to help them obtain appropriate treatment.

It is our opinion that many social services clients have fallen through the cracks in many different systems, including the mental health system.

Let me now turn to my colleague Joe Virdiramo, who will outline our recommendations to you.

Mr. Joe Virdiramo: Thank you. Our main recommendations include:

That the province fund increased community supports, and especially increased numbers of dedicated supportive housing spaces, for persons living in the community with serious mental illness. I just want to add—Iain was talking about the police services; I'm vice-chair of the police services board—sometimes in an evening we have six officers or more attending at the hospital because

clients have been taken off the street. They're causing difficulty, they follow them to the hospital and they have to be there and stay with them until they are seen. With our police services that creates a great deal of havoc because the officers are not on the street, they're at the hospital with these people;

That the province better coordinate crisis response services with the police, acute care centres and mental health service providers, so that people in crisis receive the help they need, as well as appropriate follow-up treatment and support to prevent further crises;

That, at a minimum, the province continue to fund the TBDSSAB Ontario Works addiction services initiatives at their current levels;

That the province examine the adequacy of current inpatient treatment beds, programs and protocols for admission. We feel that the criteria which are used to assess whether or not someone is admitted to hospital, how long they stay and when they get discharged may need to be reassessed. Deinstitutionalization may have been a noble goal, but we may simply not have enough beds any more for the people who need treatment and have, therefore, applied criteria for admission that are too severe.

We believe our definition in social services, and the police services, of when someone presents a danger to themselves or others and requires treatment must differ from the mental health system's definition. We suggest that the committee examine the issue of consent to treatment, particularly when people have been brought to the hospital by police.

One of our shelter providers notes: "What exactly constitutes a danger to yourself? Does being completely disoriented, dressed in rags and sleeping on the sidewalk represent a danger to yourself, or is it just a danger for certain segments of society but fine for others to endure?"

In the winter, elderly ladies with Alzheimer's who are inappropriately dressed, confused and wandering the streets are whisked away and admitted for treatment immediately, but 40-year-old aboriginal alcoholic schizophrenics, possibly with developmental delays, as we have found, are sent to a homeless shelter or left to fend for themselves with no follow-up treatment.

TBDSSAB recommends the appointment of a lead agency in the district of Thunder Bay for application and waiting list management for all supportive housing in the district of Thunder Bay which would centralize this function, bring about consistency in application, improve customer service, offer sound waiting list statistics for strategic planning and improve services for individuals requiring mental health and addictions support.

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Currently, prescribed supportive housing providers are responsible for receiving applications for special needs housing—supportive units only—assessing for eligibility and maintaining a waiting list. In addition, there are a number of dedicated supportive housing providers under provincial jurisdiction that also perform the same

functions. While the TBDSSAB receives ongoing requests for more supportive housing in our service area, our ability to determine the need and scope of this type of housing is challenging under the current system.

Please note that TBDSSAB wishes to work in partnership with our colleagues at the local health integration network, the Ministry of Health and Long-Term Care and other provincial ministries to improve the access of our clients to mental health services. For example, some of our existing social housing facilities may be appropriate for mental health supportive housing units, but what we need is the expertise and services provided by funded mental health programs to provide client supports.

We wish to commend the province for its partnership with St. Joseph's Care Group for supportive housing in the Seniors' Centre for Excellence and hope that something similar is possible in the area of mental health.

Accessing mental health services in Thunder Bay is extremely complicated. There should be a one-door entry. However, currently, individuals must fit particular criteria to obtain the services. Some must also have a diagnosis from a medical practitioner before the program will accept them; some programs will not accept co-occurring clients; some programs do not want the more severe cases; some do not offer outreach services; some will give clients one attempt to make appointments and then discharge them. We find that our clients need a lot of support to get through the door and even more support to stay with a program once accessed.

As noted above, it has been our experience that there are different definitions, protocols and eligibility criteria for services that create barriers. Creating a client-centred system—making every door the right door—means a shift in culture in mental health and addiction services, in the health system and in the broader community service systems. According to the discussion paper's authors, "To get to where we want to be, we must change the way we work. There must be more collaboration and fewer silos. We must make effective use of change management strategies, such as communications, information technology and implementation plans."

Finally, we would like to note that it is not the intention of TBDSSAB to criticize or debate the extent or direction of mental health system reform efforts or the quality of mental health services available from the many excellent programs that are in operation. We wish to work in partnership to improve access of our clients to those services.

Mr. Chairman, members of the select committee, thank you for your time today and an opportunity for us to present what we see are the needs of people we serve. We look forward to any questions you may have.

The Chair (Mr. Kevin Daniel Flynn): Thank you. *Interjection.*

The Chair (Mr. Kevin Daniel Flynn): Is that right? Okay. Let me start with two really quick ones. Who funds ASI now? Which ministry is it?

Ms. Mary Lucas: Community and social services.

The Chair (Mr. Kevin Daniel Flynn): Thanks. Where I'm from in Oakville, the Halton regional police have what they call a COAST program, and that is, they team up social workers with police officers. Often a call that is expected to be a mental health call is accompanied by a social worker, and often the social worker will take over and the police officer can go and do what police officers do best. Is anything like that in place in Thunder Bay?

Ms. Mary Lucas: No, there isn't.

The Chair (Mr. Kevin Daniel Flynn): Okay. Thank you. Sylvia, you're first up.

Ms. Sylvia Jones: I wanted to get back to your recommendation about an appointment of a lead agency in the district of Thunder Bay for application and waiting list management for all supportive housing. It's on page 5. How many are there now? I'm assuming that's the reason you put that recommendation forward.

Ms. Mary Lucas: I couldn't give a number but it would be in excess of 10, because, for example, each supportive agency maintains its own lists.

We can provide that information as a supplement to our report.

Ms. Sylvia Jones: So you're looking for a centralized list, essentially, to see what the unit has to offer, and where it is?

Mr. Iain Angus: Certainly it helps us to manage demand. We went through this with long-term care. A number of years ago the province put in place a central coordination facility, through the CCAC and its predecessor, and that has really helped us get a handle on the actual demand. A number of people are on a number of lists and everybody uses their list to justify the funding they need, and yet we don't have a clear picture.

Ms. Sylvia Jones: Okay.

The Chair (Mr. Kevin Daniel Flynn): Howard?

Mr. Howard Hampton: I want to go back to something I asked earlier, only because you go back to it in your presentation here. When governments in the past announced that they wanted to move toward deinstitutionalization—that institutions like Lakehead Psychiatric Hospital would become much smaller and provide a much narrower range of service—we were told that these services were going to be made available in the community: "We're going to move out into the community, and we're going to provide services in that way." Yet everywhere I go, people say that didn't happen.

Why didn't it happen? What happened to the services that used to be available in institutions like Lakehead Psychiatric Hospital? I think we all know that literally tens of millions of dollars worth of resources must have come out of those facilities. Where did the money go?

Mr. Iain Angus: Certainly my sense over the years is that while there was a promise of community programs being in place, and at a certain point in time they were starting to get put in place, there was a time lag. A decision was made in year X, but it wasn't until year Y that the community programs were in place. In the meantime, there were already people living without supports in the

rooming houses and apartments in the low-income sections of town, getting evicted, getting further into addictions and just severely aggravating the mental health situation they were in and spreading it. Mary?

Ms. Mary Lucas: I think the most poignant point for me in this issue would be that the client must be willing to engage. What we see are the most traumatized individuals in the system, and that has been noted by St. Joe's. They cannot engage, because they don't have the ability or the know-how to engage. They're not willing participants in the system, and that's where I see a major flaw, if there is anything that could happen in terms of reforms. A person who is schizophrenic and who is not taking their medication will not engage in services.

Again, with the individuals we've identified, we've been able to do that basically with hand-holding to get them into testing and to get them on ODSP. But once they're on ODSP, they are on their own. They're left without supports. That's the flaw. Before, you could incarcerate, you could keep someone in the system. The willingness on the part of the receiver has to be there, and that's a flaw.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Mary.

Liz, you're next. We've got Community Living from Dryden and Sioux Lookout on the phone too, so can we just keep this brief?

Mrs. Liz Sandals: I just want to follow up—this is another one-door question, but this time the one door for mental health and addiction services, which is a huge issue. Everywhere we go, we hear about fragmentation of service: Nobody can figure out how to get matched up with the right service—silos.

Who should be responsible for setting up the one door, and who would operate the one door? Any advice there?

Mr. Iain Angus: Let me answer the first part, and I'll leave it to Mary to answer the second part.

The "who" should be the province of Ontario. The province has the constitutional authority on this issue. They've got the bigger dollars; they've got the ministries. They need to decide who is going to be in charge, much like they did around the whole issue of long-term care. Mary?

Mrs. Liz Sandals: But you don't have any particular advice as to who that sensibly should be?

Mr. Iain Angus: I'm going to leave it to Mary, who lives this every day, as opposed to me, being the chair.

Ms. Mary Lucas: Certainly, at our level, again similar to what is happening in social services—Ontario Works and child care—the province sets the parameters and lead agencies are mandated. Clearly, St. Joseph's is the lead agency in our community and is responsible. I think that setting the legislative parameters is critical. There are agencies that could do that work, and the largest in our community is St. Joe's.

Mr. Iain Angus: I think that's the one with the most expertise.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for attending today. Thanks for a very thorough presentation.

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SIoux LOOKOUT
COMMUNITY ACTION PARTNERSHIP
FOR FETAL ALCOHOL
SPECTRUM DISORDER

The Chair (Mr. Kevin Daniel Flynn): Is that Judy, Bruce and Janet?

Ms. Judy Kay: Hello. This is Judy, and we're all here.

The Chair (Mr. Kevin Daniel Flynn): Wonderful. We've got you on the line right now. Most members of the committee are here today. We're short just two. Every member except Christine Elliott and Jeff Leal is here. We've got Howard Hampton sitting in for France Gélinas. Outside of that, you know all the other members of the committee.

You've got 20 minutes to make your presentation. You can use that any way you see fit. If you could leave some time at the end for some questions, that would work out great. It sounds like the place you're sitting at is working well; I can hear you.

Ms. Judy Kay: Great.

The Chair (Mr. Kevin Daniel Flynn): Just make yourself comfortable, and we're all yours.

Ms. Judy Kay: Okay. Thank you very much. This is Judy Kay speaking, from Healthy Generations Family Support Program. I'm employed by Community Living Dryden-Sioux Lookout.

Today we are speaking to you on behalf of a large committee of people in Sioux Lookout who are called the Sioux Lookout Community Action Partnership for Fetal Alcohol Spectrum Disorder.

I'm just going to ask the other two people I'm with to introduce themselves and their organizations.

Ms. Janet Paterson: Good afternoon. I'm Janet Paterson, the director of services and development for the Patricia Centre for Children and Youth. We're a children's mental health centre located in the communities of Dryden, Sioux Lookout and Red Lake. We also cover some of the more rural and remote areas. Thank you for the opportunity to speak with you today.

Mr. Bruce Siciliano: Good afternoon, everyone. I'm Bruce Siciliano, the director of Sioux Lookout Meno-Ya-Win community counselling and addiction services. We have an adult mental health and addictions mandate, as well as a youth addictions mandate. We serve the areas of Sioux Lookout, Hudson and Pickle Lake. We also provide services for people who come in from the 31 First Nations north of Sioux Lookout.

Ms. Judy Kay: We're really pleased to present to you today and to speak with you about fetal alcohol spectrum disorder and the impacts of fetal alcohol spectrum disorder on the mental health and addictions system.

Sioux Lookout and the district have been working on fetal alcohol spectrum disorder since the early 1990s. I understand that your committee made a trip to Sioux Lookout last week or the week before. We're pleased to know that you've seen Sioux Lookout and the north, and that you now have an understanding of the context of the information we're about to provide to you. I think it's really great that you made it up to Sioux Lookout and that you got to see our communities and some of our challenges and, as well, our strengths.

The Sioux Lookout Community Action Partnership for Fetal Alcohol Spectrum Disorder is a fairly new initiative, but it is also an extension of work that has been conducted over the course of about 15 years. Our mission for the partnership is to develop a community action plan that will lead to the creation of a comprehensive and sustainable service network aimed at effectively identifying and responding to the unique needs of children, youth and adults and their families affected by fetal alcohol spectrum disorder.

It's interesting, with your interest in mental health and addictions, that this project is funded by the Provincial Centre of Excellence for Child and Youth Mental Health, and it is a community mobilization award.

I know that you have the PowerPoint presentation in front of you. We've listed the partners for you. We have 15 partners at this table, and we'll be expanding next month to include more partners and more interest groups.

Just to give you an overview of what we're trying to do here today: We're trying to say to you that the province, but especially Sioux Lookout and district, needs the opportunity and the resources to address the devastating effect of FASD on individuals, families, service provision and service providers, and on our communities. FASD, left unaddressed, creates a huge impact on the whole system.

The solution lies in our response and starts with support for women, diagnosis, appropriate treatment for those affected, and supports within the community to address this.

What we'll be doing today, basically, is talking to you about what FASD is. I'll be providing you with some very quick background information, and we'll talk to you about the impact of FASD on the mental health and addictions system. We also have for you some very clear-cut and thought-out solutions.

Very briefly, what is FASD? It's an umbrella term used to describe the range of effects that can occur in an individual whose mother drank alcohol during pregnancy. It is a very serious health and social concern to Canadians, and it is the leading cause of developmental and cognitive disabilities among Canadian children.

FASD is a permanent form of brain damage. It's a full-body experience in disability. It affects all aspects of a person's life, and without accurate diagnosis and a support system specifically designed to address the disability, the problem is further complicated. It's very, very clear that the low level of societal protection and

support afforded to them by our system compromises their lives far beyond that caused by their disability.

In terms of prevalence, in a general community, we're seeing about 1% of all births being affected. It's the leading cause of developmental and cognitive disabilities. We have high rates in northwestern Ontario. One community found a positive screening of 23% of the students in the school. A Manitoba study found that 10% of live births were affected. So we see pockets of high prevalence rates in particular areas.

There was a large study done in the University of Washington that looked at 700 people who had fetal alcohol spectrum disorder. Within that group, they found that 90% had mental health problems; 60% had experienced disruptive school, so were kicked out or suspended; 60% had trouble with the law; 50% had experienced confinement; 50% had been a victim or perpetrator of inappropriate sexual behaviour; and 30%—this included children—had trouble with alcohol or drugs.

So looking at some of the key points for you to consider, early intervention absolutely improved outcomes. We definitely know that adolescents and adults have unacceptably high levels of difficulty managing in society, and often have very poor outcomes. The brain damage is significant, but it is rarely understood. Many people with FASD unfortunately do not conform to current standards or guidelines for service eligibility, or the appropriate level of service is not available. There are two issues there: eligibility and services available. Without appropriate support, adulthood presents a crisis point.

Just to help you connect the dots, although I'm sure you're thinking hard there, people with FASD are at high risk for mental health disorders and other serious social impacts. We are already providing these services to people with FASD, but in a very ineffective and costly fashion. So consider the cost of treatment homes: \$300 to \$800 a day for a child. Consider the cost of one day of jail. Just continue with that thinking, and imagine if we could redirect that money. FASD crosses all sectors and therefore calls on all of us to find a solution.

I'm just going to walk you through a little bit of information about children and adults. I'm not going to go through this whole slide, but I wanted to point out a few things, and I'll let you look at that later.

There's a very high rate of family and foster home breakdowns. In my work, I see family home breakdowns almost every week, and it's due to the disability not being supported.

For children who have FASD, the biggest complaint they speak to me about, their biggest sorrow, is that they're isolated from other children and they have no friends. Some 80% of children with fetal alcohol spectrum disorder do not stay with their birth families.

Tikinagan reports, in the book called *Coming Home*, that providing community care to children with fetal alcohol spectrum disorder is more difficult. Children frequently are placed in outside group care programs and residential treatment facilities in distant places.

Kenora-Patricia Child and Family Services researched statistics on FASD within their organization. Out of 213 children in care, 41 children had a diagnosis of fetal alcohol spectrum disorder and 86 children had an identifying factor and should have an assessment, resulting in 60% of the children in care potentially living with FASD. I just wanted to point out to you that we no longer have access to diagnosis, so that high rate of diagnosis within those Kenora-Patricia Child and Family Services children will be going down, because we don't have access to diagnosis at this point and we did previously. The overwhelming majority of children with fetal alcohol spectrum disorder, 89%, were found to be in the permanent care of a children's welfare organization. That was found by a Manitoba study.

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So, considering some of the key points with adults: Society is not so forgiving toward adults. They have difficulty navigating what seem to be simple tasks: filling out applications, attending appointments, following through on children's welfare probation orders, buying groceries, budgeting. Large portions—very large portions—in Sioux Lookout struggle with homelessness. The absence of housing is the absence of everything.

A very important point for you to keep in mind is that often people with fetal alcohol spectrum disorder do not conform to standards for service eligibility, or they're waitlisted for adult developmental services or mental health services. Of course, we see a high rate of substance use, especially when this condition isn't diagnosed and treated, and trouble with the law. People with FASD often will repeat the FASD cycle. So I see, in families where women who have fetal alcohol spectrum disorder haven't received treatment and care, who have three-plus, up to 11 children, in some cases all those children have been exposed to prenatal alcohol. As adults, lives often spiral out of control. The cost to them, their families and society at large is incalculable.

So, looking at your interests that you have at this table today, how does FASD impact mental health and addictions? Well, we know from that secondary disability study that 90% of those clients that had FASD suffered from a mental health disorder. Depression has been reported in up to 40% of the adults affected by FASD and, interestingly enough, adults with the highest IQ have been found to have the greatest overall adjustment problem. Looking at dual-diagnosed people—so people who have fetal alcohol spectrum disorder, and another diagnosis of a mental health disorder—it was very evident in almost half of the children described in a Manitoba study.

Something else to point out to you is that often a person with co-occurring fetal alcohol spectrum disorder and mental illness—so FASD plus the mental illness—who is not diagnosed is often not diagnosed with fetal alcohol spectrum disorder. The failure to recognize co-occurring disorders can increase the risk of inappropriate treatment, resulting in homelessness, alcohol and drug problems, legal problems and premature death.

Having a very quick look at fetal alcohol spectrum disorder in the criminal justice system: 23% of young offenders in BC, in a study done in 1997, had symptoms of fetal alcohol syndrome or fetal alcohol effects, which come under the umbrella of fetal alcohol spectrum disorder. A study was done at Stony Mountain prison, and with that study 10% of the sample were identified with FASD and a further 16% to 18% were found possibly to be affected by FASD. The FASD-identified were 10 times more likely than the normal population to have 15 or more convictions. Our criminal justice system is based on the premise that individuals have the mental capacity to appreciate the nature and the consequences of their actions, including the connection between an intentional act and punishment. Individuals with FASD challenge this underlying assumption. The management of people with FASD in the criminal justice system uses extensive resources that could be used in other areas.

So that was quick, but this brings us to our two slides, our 10 points that we're bringing forward as solutions. I just wanted to make you aware that I've been working 15 years in the field. I work with children and I see some very exciting results happening with children when they're identified early and diagnosed early, families are informed, we get to work with the families, they receive good support, and those children are now just coming up into adult services and they're doing very well. So even though I've presented you with some fairly serious statistics here, I'm telling you that we can do much better and that the children whom we're working with at this present time show us how well we can do. We just need to keep supporting them.

In terms of solutions, we need prevention programs that address marginalized populations of women who are impacted by substance abuse and related conditions.

We need access to diagnosis closer to home. At this time, Sioux Lookout is expected to travel to Toronto to receive an assessment. That's like asking Toronto to travel to Florida. We do have a proposal out. It has been out for more than a year. I am planning to send a few copies down to your committee for you to have a look at. We are capable of running a diagnostic clinic here in Sioux Lookout. We did do a pilot project for 18 months, but that clinic had to close its doors in July 2006 because operational funding wasn't provided beyond the pilot project, and that was despite success having been proven and a very high need proven as a result of that pilot project.

Going down the line, looking at solutions, we need removal of barriers and provision of appropriate interventions throughout a lifetime.

We need targeted funding for case management and service delivery specific to fetal alcohol spectrum disorder.

We need deployment of a flexible pool of resources targeted for FASD in order to provide a comprehensive package of services that address the multi-faceted complexities.

We need long-term, structured, supervised residential, educational and daily supports for people living with

FASD and caregivers, with a particular focus on looking at youth who are approaching the adult service system.

We need funders to think outside of the box, realign the resources and provide us with funding options and the flexibility to respond to the local reality of the individual with FASD and their caregiver's needs.

We here have solutions and we require the support and the integrated effort of multiple ministries and funders to do what needs to be done.

We need assistance and support with the implementation of FASD community-based strategic plans.

On a final note, before we open it up for more discussion, fetal alcohol spectrum disorder crosses all sectors of the government and the full range of community-based organizations. Therefore, the solution must come from that wide collection; not any one ministry should be responsible. No single organization can do this alone and all partners should be held accountable.

That is our formal presentation. I have Bruce and Janet here as well, and they're very able to comment further on any of this information.

The Chair (Mr. Kevin Daniel Flynn): That's wonderful. Thank you very much for the presentation. We've heard from fetal alcohol syndrome groups, I think, at just about every stop this week, so every time we hear from you, we learn a little bit more. You've left about three minutes for questions. We're going to start with Howard.

Mr. Howard Hampton: Thanks for your presentation. I want to ask this question because I think people need to get their heads around this: Speaking for the Sioux Lookout area, in your view, is the incidence of fetal alcohol syndrome greater, diminishing or staying the same? And related to that, are the problems that result from FASD growing, diminishing or remaining about the same? What's your experience?

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Mr. Bruce Siciliano: They're growing, Mr. Hampton, and we know that in the adult sector that I'm working in because the majority of our mental health and addictions assessments now are of the serious nature: serious mental illness, serious addiction, comorbid with fetal alcohol spectrum disorder and developmental disabilities. Our caseloads are increasing, so we just know from the numbers of people that we're seeing that it's no longer acceptable to provide traditional talk therapy in our adult mental health and addictions agencies anymore. These people require a comprehensive package of services—with talk therapy, of course, as an adjunct.

So in my agency, we're constantly working on our budget to invest dollars in the community to provide different interventions and different solutions for people; for example, working with our local associations for community living, which don't have money to provide beds for people with fetal alcohol spectrum disorder. So we're actually working on our base budget and flowing dollars to our associations for community living so that people with FASD can have a bed, so that we can

provide addictions and mental health work to those folks, and so that they also have a safe place to sleep.

We have to partner with our homeless shelter here in Sioux Lookout, because if you look at the majority of the people in our homeless shelter, they have fetal alcohol spectrum disorder with a co-occurring mental health and addictions issue. So it's definitely increasing, and it's not just the number that's increasing; the severity is increasing. These are life-and-death situations in our community.

Ms. Judy Kay: I would just quickly add that the very lack of diagnostic services prevents us from having accurate numbers. We do believe that our incident rate is much higher, but it's hard for us to prove that when we don't even have access to diagnosis at this point.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much, Bruce, Janet and Judy. Unfortunately, we've used up all our time, but I did want to thank you for taking the time to join us in Thunder Bay here today.

Ms. Judy Kay: Okay. I would just like to add that I did send a copy of a DVD called *Picture This: Life as a Parent of Children with FASD*, and I would ask that everybody view the video and know that that was created in Sioux Lookout by mothers who have a message to give you to make changes on behalf of their children, some of whom are aging out of the adult care system and have nowhere to go. In fact, three of the children talked about in that video have nowhere to go in six months to a year because there's no provision for them. They don't qualify for developmental services and they are not able to look after themselves.

The Chair (Mr. Kevin Daniel Flynn): Thank you. All members received a copy of that.

Ms. Judy Kay: Thank you very much.

The Chair (Mr. Kevin Daniel Flynn): Thanks for joining us.

DRUG AWARENESS COMMITTEE OF THUNDER BAY

The Chair (Mr. Kevin Daniel Flynn): Our next presentation today is the Drug Awareness Committee of Thunder Bay, Jennifer McFarlane and Patty Hajdu. Come forward and make yourselves comfortable. There are still some clean glasses over here if you need some water. Any mike will do. Every group's getting 20 minutes. You can do anything you want with that 20 minutes, but if you'd like to leave some time for some questions at the end, you can see there's interest from the committee members in a discussion.

Ms. Jennifer McFarlane: Does that include interpretive dance as well within the 20 minutes?

The Chair (Mr. Kevin Daniel Flynn): You know what? We've been doing this all week. We're open to everything. It's all yours.

Ms. Jennifer McFarlane: Thanks. Hi, everyone. My name is Jennifer McFarlane. I'm a health promotion planner for alcohol and substance misuse and I work at the Thunder Bay District Health Unit. I'm also the chair

of our drug awareness committee. With me is Patty Hajdu, who's the coordinator of our municipal drug strategy. She works at the Thunder Bay District Health Unit and is the past chair of our drug awareness committee, so we work together on a number of projects.

We would first like to recognize the effort that was put into developing the discussion paper and we would like to compliment the advisory group on its comprehensive approach. We appreciate the steps taken to ensure an inclusive process, and specifically we would like to commend the minister for establishing an interministerial group.

Ms. Patty Hajdu: The Drug Awareness Committee of Thunder Bay is a collaboration of organizations that have an interest in or conduct work to reduce alcohol and substance use-related injuries, deaths and crimes in Thunder Bay and the northwestern Ontario district. We've been in existence since 1991 and we take a comprehensive approach to the issue of substance misuse by working on raising awareness of the issues of substance misuse through media campaigns, education sessions and presentations.

We work to support healthier environments as well for youth and the general public through projects that increase resiliency and build on strengths, such as peer mentoring programs and school leadership clubs.

We also monitor existing and emerging public policy that affects or addresses substance issues, and we conduct advocacy work as appropriate. We will provide you with a list of our partners as well.

I'm just going to give you a little bit of a snapshot of some of the statistics that we have. Maybe you've heard this already today, but one of the projects that we work on collaboratively with the Northwestern Health Unit and the Thunder Bay District Health Unit is the northwestern Ontario student drug use survey, which is a survey of student drug use that we conduct every four years. It's very closely aligned with the CAMH student drug use survey. In fact, Ed Adlaf has supported us in this initiative for many years. This is our fourth round that we've conducted. Actually, we've just completed the 2008 survey; we don't have stats for you that are that new, but the stats that I'll be telling you a bit about are from 2005.

In the 2001 and 2005 cycles of the survey, the survey demonstrated that youth in northwestern Ontario and Thunder Bay have a significantly higher incidence of alcohol and substance use as compared to youth in other parts of the province. First-time use for alcohol, tobacco and cannabis begins in and about grade 7, and it peaks in grade 9. These first-time use rates are higher in northwestern Ontario region. This is significant because early use of alcohol and substance are linked to higher rates of substance abuse and alcohol problems later in life.

In addition to higher first-time rates, youth in northwestern Ontario have significantly higher than provincial average usage rates of cannabis, stimulants, hallucinogens and methamphetamines. Youth in northwestern Ontario also report higher rates of binge and hazardous drinking.

In 2005, due to emerging reports of increased opiate misuse amongst youth, the survey questioned youth for the first time about their non-medical use of OxyContin specifically. The resulting data demonstrated that non-medical use of OxyContin in northwestern Ontario is nearly four times higher than across their provincial counterparts.

The Northern Ontario Child and Youth Health Report, which was conducted in June 2003, also draws some startling comparisons between northern Ontario children and children from the rest of Ontario. According to that report, substance-related mental health disorders are higher in our region for both adolescent males—33% as compared to 21% provincially—and females, with 18% as compared to 12% provincially. Illicit drug use was reported by 35% of youth in northern Ontario.

Something else we have been doing for the past several years is that we have a peer mentoring project that Jen will speak about a little bit more. It's conducted in our local high schools. In that process, we survey high school youth about what issues they identify as concerning to them. Drug use has placed in the top three concerns out of a list of 25 identified concerns for the past three years.

Youth in Thunder Bay report that they feel concerned that drugs are very easy to access in school and that it affects the functioning and health of their peers. They also, incidentally, talk about stress and depression quite significantly in those surveys.

Prescription opiate misuse, as you're probably very well aware, is becoming quite a significant challenge for our communities. The district of Thunder Bay is struggling with a significant increase in community members struggling with addiction and the harmful use of opiate-based medication. We've witnessed a series of pharmacy break-ins. All drugs that were taken were opiate-based pain relievers such as Percocet, Percodan etc.

Wait lists are high at both the private and the publicly funded methadone clinics. Thunder Bay has identified a lack of withdrawal management services, especially for those who have complex medical needs, and many people who have opiate addiction present with extremely complex medical needs.

Some First Nations communities have declared a state of emergency as a result of the crises they are experiencing in their communities. Social agencies such as Dilico Ojibwa Child and Family Services, the children's aid society and Ontario Works indicate that they are seeing a large increase in families that have been affected negatively by a member misusing prescription opiates, which leads, of course, to financial and personal stress and the inability to parent or maintain employment.

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Ms. Jennifer McFarlane: Our drug awareness committee has supported a variety of projects over the years, most of which were focused on prevention initiatives. During this time, the drug awareness committee has really evolved from traditional social marketing campaigns—things like posters and media displays—to

focusing our resources on a more comprehensive health promotion approach. We strongly support the brief prevention highlight within the strategy, section 1.4, and agree that prevention and early identification are priorities.

Another key area identified in the strategy, section 7, is building community resilience. Prevention and resilience-building has been our main focus for young people, and I would just like to comment on a few of the programs that have been successful in our district that promote peer mentorship and youth development, which we strongly believe is key to prevention.

One example is the Natural Helpers peer mentorship program. It's been operating through the drug awareness committee and local high schools for over five years now. The Natural Helpers peer mentorship program is unique in that its approach rests on the premise that there are already members of every community who act as support resources, or natural helpers. The Natural Helpers program builds on this premise by enhancing those helpers' skills and providing them with support resources and referral skills to enable them in their efforts to act as mentors and friends. So the goals of this particular peer mentorship approach are to teach the natural helpers effective ways to help their friends, to teach them positive ways of also taking good care of themselves, and to teach them how to contribute to a safe and supportive environment.

We've included some evidence that supports peer-to-peer approaches within our paper. We have a few copies here, and we will e-mail it as well so that everyone can get a copy. But basically, the common message states that peer support programs address protective and risk factors, develop youth competencies, create caring environments, identify areas of concern, and provide meaningful youth involvement. So these types of programs understand and involve youth. They are involved in identifying issues relevant to them, and youth decide which issues to address and how. These types of programs are an effective process leading to enhanced group interaction and knowledge and skill development.

The second successful program that I would like to highlight is the tobacco control strategy's Youth Action Alliance program. Despite recent cuts, unfortunately, this program was well regarded as a successful youth development model. So youth aged 14 to 19 were hired as employees of health units and partner organizations to work on tobacco prevention initiatives. Such initiatives involved peer-to-peer education, advocacy efforts, social marketing and policy change. Each Youth Action Alliance had a paid adult mentor—which was key to the success of the program—in the form of a youth adviser, and special care was taken to ensure a diverse group of youth with a variety of lived experiences were hired. The program offered paid job opportunities as well as skill-building and positive social outlets and interactions with both youth and adults within health areas.

Finally, the third program is unique to the city of Thunder Bay. The drug awareness committee supports a

leadership program at Dennis Franklin Cromarty High School for aboriginal youth from remote reserves who have come to the city to attend school. The leadership group provides an opportunity for youth to talk about social and health issues that affect them. Their most recent campaign, called Just Ask Me, is an anti-racism campaign designed by the youth. The campaign aims to break down stereotypes and encourages communication between aboriginal and non-aboriginal youth through an interactive website. We'll be launching a movie theatre commercial in the fall—and other media outlets.

So much of the past work around substance and alcohol use prevention is focused on awareness and education. These types of programs that I've described build on that work by creating a supportive environment, which is essential to assisting youth in maintaining mental health, developing resiliency skills, learning, beginning to trust, and using the resources available to them in their community; also, avoiding substance and alcohol use and ultimately becoming a productive member of society. Such programs as these also empower youth to contribute to the health of their peers and community through the design and facilitation of health promotion strategies that address the needs of their peers.

While recognizing the importance of peer-to-peer education and youth development, it is also essential to recognize the resources required to build and maintain youth programming.

It's our recommendation that adequate funding be put into place to support successful prevention initiatives, and that those resources be sustained over a long period of time.

Specific resources and funding from the ministry to supply additional social worker support in schools is also essential. This should not be left up to school boards to fund but should come directly from the ministry and should also include additional training for teachers and guidance counsellors.

Ms. Patty Hajdu: The drug awareness committee would also like to comment on the importance of equitable funding for northern training opportunities. Often, geographically isolated communities don't have the same access to training and development opportunities as their southern counterparts. Access to technology is often not in place, and there are limited ways to participate.

It is our hope that the needs and challenges of the entire province are considered and that people living in all regions are consulted throughout the ongoing process.

Not only in Thunder Bay but also in the outlying communities, there is a great need for additional treatment options, beds and, critically, aftercare programs. For many remote communities, when a person receives treatment in a larger centre, they often return to a community that has no resources or support for continuing care. This results in a very high relapse rate for these individuals.

Culturally relevant programs must also be offered for the large aboriginal population in the north.

It's obvious to us that much thought has been devoted to the influence of social determinants of health as they relate to the prevention of mental health and addiction issues, as well as how they influence a person's ability to heal and move forward in their lives.

We are also very encouraged that this is an inter-ministerial approach, as it is only by collaboration that we can address a person's situation in a truly holistic way.

We are concerned, however, with sections 6.5 and 7.1, "Promote Healthy Lifestyles, Including Self Care and Exercise" and "Strengthen Health and Wellness Promotion in Communities." Although we agree with the benefit of healthy behaviours, such as nutritious eating, adequate exercise and sleep, and reduced tobacco use, the barriers for people with mental health and addictions issues are vast and stem from the fact that many people are struggling with low income and unaffordable housing, stigma and exclusion, and lack of basic necessities.

For section 6.5, the concern is that the word "lifestyles" suggests choice and in fact diminishes the demonstrated evidence that with additional income and stable housing, many individuals indeed begin to adopt healthier behaviours. Many individuals would choose fruits and vegetables over highly processed, fat-laden foods if they had adequate income. When people are not exhausted from searching for a safe place to sleep or raise their children, more time becomes available for what are often perceived as leisure activities, including walking for no purpose instead of to an appointment or a convenience store, or running for exercise instead of away from something.

We also caution that health promotion that is based on telling people how to behave is a very limited approach. Comprehensive health promotion is necessary for any intervention to be successful. This includes strategies that change both environments and policies to make the healthy choice the easy choice. People must be able to afford and engage in health activities before they will do so, no matter the quantity or quality of health promotion campaigns.

Programs that work to include people are mentioned in 7.1, "Strengthen Health and Wellness Promotion in Communities." Others that have been effective and provide support in a non-stigmatizing way include the very successful PRO Kids in Thunder Bay, a model program that has been adopted internationally. This program works with organized youth activity providers to provide free spots, which are then utilized by children from homes without adequate income to otherwise engage in that activity.

Ms. Jennifer McFarlane: In conclusion, the drug awareness committee supports the comprehensive directions outlined in the discussion paper and is excited about a 10-year mental health and addictions strategy. We look forward to hearing about the progress of the strategy and the implementation plans as they develop.

While we are extremely encouraged by this comprehensive document, we have a concern. We have seen

many task force reports, research documents and recommendation reports from all levels of government on the issues of not only mental health and addictions but also on poverty, social exclusion, racism, housing etc. How will adequate resources and collaborative efforts be made to ensure that this will be implemented? Also, can you comment on a strategy timeline or projected rollout?

I should have asked, are we allowed to ask questions?

1510

The Chair (Mr. Kevin Daniel Flynn): You know, you kind of just did.

Ms. Jennifer McFarlane: I did. Sorry.

The Chair (Mr. Kevin Daniel Flynn): It's tough to stuff it back in after you've let it out.

Ms. Jennifer McFarlane: I know. I should have asked at the beginning.

The Chair (Mr. Kevin Daniel Flynn): No, you—

Ms. Jennifer McFarlane: I'll sum up by saying thank you for travelling to Thunder Bay and hearing our thoughts and recommendations.

The Chair (Mr. Kevin Daniel Flynn): Okay. That's good. Actually, that was a good segue. I just wanted to make sure that you understood the process that's underway. Minister Caplan has an advisory group, which put together the report you referred to a lot in your presentation. Our group that you're before today is a select committee of the Legislature made up of members of all parties. We're to report back in the spring of next year, not to the minister and not to the ministry, but to the Legislature itself. The minister, at the same time, has his own advisory group and has put this report out for comment. He's looking at a 10-year strategy; we anticipate our report will come back with some much shorter-term issues and answers, we hope. We're to report back in the spring, so we're travelling the same road. It's just that, I think, the minister is looking at a much longer-term view whereas the view from this committee is what we should be doing in the next few months and years.

Ms. Jennifer McFarlane: Thank you.

The Chair (Mr. Kevin Daniel Flynn): We still have a little bit of time for questions, if we can be quick with it. Helena.

Ms. Helena Jaczek: As a former medical officer of health, I really want to say that I appreciated your description of the health promotion programs that you're engaging in here in Thunder Bay. My question actually relates to what Mr. Hampton was asking earlier. Between 2001 and 2005, did you see an increase in use?

Ms. Patty Hajdu: An increase in use amongst youth?

Ms. Helena Jaczek: Yes.

Ms. Patty Hajdu: What we found is that there has been an increase in cannabis but not necessarily alcohol use. The usage rates have actually gone down slightly overall. I guess the point that we're trying to stress today is even though the usage rates overall have gone down, they're still so much higher than the provincial counterparts. That's our concern really: even lowering them still so that they're equivalent to what the province is seeing as a whole.

Ms. Helena Jaczek: Of course. Can you attribute any of that alcohol use decrease to any particular circumstance?

Ms. Patty Hajdu: That's a question that comes up over and over. It's very difficult to speculate. Sometimes it can even just be the way the data is collected. We did notice a decrease from 2001 to 2005, but we also had a change in the way the data was collected. It's actually quite interesting: We've done a different process in terms of consent forms. Consent forms are the kicker. What would happen before is every child who participated in the student drug-use survey had to have a consent form signed by a guardian, essentially. As you can imagine, the problem with that is that the kids who are most at risk don't have a guardian, or don't bring the paper home, or don't get the paper back, and so you get to survey all the kids who are doing what they're told, in essence.

This year, we were able to pass, through our board of health and through the Northwestern Health Unit as well, a process called active information, passive consent and active dissent. Basically, parents have to indicate if they don't want their child to participate. So we're really excited to see what the data will hold for us here in 2008. Our guess is that the rates are going to be much higher, in fact, than they were before, because now we really will be capturing the data from those kids who are less involved and have less-effective households in terms of getting forms back and that kind of thing.

The Chair (Mr. Kevin Daniel Flynn): Sylvia, we've got time for one short one.

Ms. Sylvia Jones: Your Natural Helper peer support program, tell me how you're funding that. Are you training the peer support individuals? Expand.

Ms. Patty Hajdu: The funding was originally through crime prevention strategy funding, which was federal funding, and we received two years of that before the crime prevention strategy changed its focus to what they considered prevention but what we considered actually more upstream. They wanted to focus on gangs and guns. Our argument at the time was "We're trying to prevent kids from getting to the gangs and gunning stage," but that didn't wash.

Then we had a year where we basically cobbled together resources in the health unit and pulled from different sources, and so it was the Thunder Bay District Health Unit that supported it for a year. Then, we were fortunate to receive Trillium funding, and we received three years' worth of Trillium funding, which comes to an end actually this year.

But part of the challenge has been that part of that program is teaching kids when to refer, because one of the strengths of the program is that it builds on this already innate behaviour of adolescents confiding in each other, but what we find is that sometimes the problems are too big. For example, a friend discloses that they feel like killing themselves, and the friend who is the natural helper doesn't necessarily know the resources or how to access those resources. Part of this program is training kids to know when it is time to pull in another adult and how to do that.

The challenge is that school boards aren't funded for social work. We have four social workers for four high schools, and each high school has at least 1,000 students, averaged out. You can well imagine that the caseloads of those social workers are extremely high. We've had some support from community agencies to come in and do some crisis support for us. But basically the frustration of that program is that we now have these kids who are trained and who know they need adult support, but when it gets to the point of adult support, the ball often gets dropped, through no fault, really, of the school boards, because they're not funded to provide those social workers. They are doing the same thing we are in cobbling together enough resources, and those social workers are hired on year-to-year contracts based on the availability of funds in those boards.

You raise an interesting question: It is very difficult to sustain, and the resources within the schools are so stretched that the schools are barely handling the problems that are the visible part of the iceberg. What we're doing is basically exposing some of the iceberg underneath, and we're in an overload situation.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming, Jennifer and Patty. We really appreciated your presentation.

BRAIN INJURY SERVICES OF NORTHERN ONTARIO

The Chair (Mr. Kevin Daniel Flynn): Our next presenters today are Peter Gravelle and Nicole Spivak-Nigro, of Brain Injury Services of Northern Ontario. Make yourselves comfortable. You've got 20 minutes to make your presentation. You can use all of that for your presentation, or you can save a little bit at the end for questions and answers. It's entirely up to you.

Ms. Nicole Spivak-Nigro: Good afternoon, Kevin Flynn and members of the Select Committee on Mental Health and Addictions. Thank you for the opportunity to present to you today. I am Nicole Spivak-Nigro, community services manager, and with me is Peter Gravelle, program director. We're presenting this brief prepared by Alice Bellavance, our executive director.

We would like to thank the current government for hosting these hearings, along with other initiatives such as consultation by the local health integration networks on the development of a 10-year strategy for mental health and addiction, and the "Open Minds. Healthy Minds." mental health and addictions strategy summit in July.

BISNO is a non-profit charitable organization that provides rehab and support services within the community to individuals with a brain injury. Since 1991, we have collaborated with other agencies and professionals to develop and provide a complete range of services across northern Ontario.

Persons with brain injuries can have a complex series of physical challenges, such as paralysis or sensory loss; cognitive problems, such as short-term memory loss and

language difficulties; and/or behavioural problems, which may include personality changes, severe mood swings or acting out. Because of the complexity of the brain and the variety of insults that may occur, each individual and the sequelae of their injury is unique. Our mission is to provide services to these individuals to assist them in attaining their optimum level of functioning and to continue living, loving and doing.

In our almost two decades of providing service, we have identified that 65% of individuals we serve have a co-occurring AXIS I diagnosis that may be pre-existing or is due to the damage to the mechanical, electrical and/or chemical mechanisms in the brain following the injury or a sentinel medical event. Of these 65% of individuals, 80% have a co-occurring addiction, which may also have been pre-existing or subsequent to their injury.

To add to this complexity, 60% of the individuals we serve have had involvement with the criminal justice system, 50% as perpetrators and 50% as victims of crime. Many have a history of violence, which can exclude them from accessing other services that they need. Should fetal alcohol spectrum disorder be part of their profile or they are of aboriginal heritage, which now represents 30% of our client base, access to services is further compromised.

1520

Since mainstream mental health and addictions services are overburdened, individuals presenting with these complex, multi-jurisdictional issues cannot be served. BISNO was successful in securing pilot funding through the North West LHIN in the spring of 2008, and we offered a specialized addiction treatment program to individuals with a brain injury and co-occurring addiction. This program was highly successful, and we have since reconfigured resources internally in order to continue to deliver this service. It has further been identified by the North West LHIN as a promising practice.

Over the past number of years, we have received more referrals from the aboriginal child welfare system for children and youth who have sustained an anoxic brain injury by attempted hanging, brain injury due to assault and other forms of interpersonal crime. Many of these children and youth have a pre-existing mental health diagnosis and/or addiction, as well as fetal alcohol spectrum disorder. The impact of intergenerational trauma and the remoteness of some of the 98 First Nation communities in our catchment area make service delivery impossible unless they relocate to an urban centre like Thunder Bay.

We would like to recommend the following:

First, that when a system design is developed, it include consumer-derived standards of welcoming, accessibility, integration, continuity and comprehensiveness, which will result in functional and integrated outcomes; and also for continuous quality improvement through enhanced capacity, access, coordination and flow for seamless delivery into service, during service and out of service; and include flexibility for the individual to

come in and out as required in order to maintain their health status.

Second, improve the health status for people living with the effects of an acquired brain injury, a mental illness and/or addiction by building healthy, supportive and accepting communities that provide fair and equitable access to the social determinants of health. Examples include health services; mental health services; income, housing, education, employment, gender, culture and social support networks and physical environment. We also want to note that Canada does not have a national housing strategy, and that there has been no development of social housing in the province of Ontario since the early 1990s. Previous initiatives, such as Project 3000, were highly successful; therefore, the wheel does not always need to be reinvented.

Lastly, we recommend that special attention be paid to First Nations people, as they are disproportionately represented in the mental health and addictions sector and in the criminal justice system, and have a high incidence and prevalence of FASD and brain injury. Further, there is a higher percentage of aboriginal children in the child welfare system who are at greater risk of engaging in high-risk behaviours resulting in injury and other forms of poor health status. Funding agencies such as ourselves developing culturally competent and safe services in partnership with aboriginal service providers and First Nations communities would begin to address this.

Thank you again for the opportunity to present.

The Chair (Mr. Kevin Daniel Flynn): You have left a lot of time for questions, which is wonderful. Let's get right to it. Everyone's going to get—

Interjection.

The Chair (Mr. Kevin Daniel Flynn): That's right. That was so thorough.

It looks like everybody's going to get just over four minutes. Let's start with Sylvia.

Ms. Sylvia Jones: I'm going to sort of change tack a bit. With acquired brain injuries, have you had any challenges with the legislative requirement that you must be diagnosed prior to age 18?

Ms. Nicole Spivak-Nigro: What we do is, if an individual sustains a brain injury, acquired or traumatic—we don't really split that hair as much with service anymore—we rely on children's and developmental services. It's the 16- to 18-year-old range where we tend to have more of a struggle. We will serve individuals 16 years of age and older. If they apply for services prior to age 16—if they apply when they're 12, 13, 14—we'll take their referral, because by the time they turn 16 they're at the top of our waiting list. It's between 16 and 18 where different mandates between different service sectors, whether it's developmental, child and youth or adult services, tend to be more hard lines versus overlapping.

Ms. Sylvia Jones: Do you have a solution for making that a little more seamless?

Ms. Nicole Spivak-Nigro: Well, part of it is that we're better able to work around it when there is the required information, either diagnostics or previous access to a service. What we've done is not necessarily a formal recipe, but because we have been working in Thunder Bay and district for almost 20 years, we've developed partnerships and we have the luxury of being very flexible in our support. So if one agency would be able to provide services and their role needs to be case management, then we won't take on the case management role. We'll look at supporting the family or facilitating different opportunities or working on job skills. That's how we've adapted around it.

Ms. Sylvia Jones: Thank you.

Ms. Nicole Spivak-Nigro: Did I answer it?

Ms. Sylvia Jones: Yes, very well. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Sylvia. Howard?

Mr. Howard Hampton: Just a couple of points of clarification. While it's the Brain Injury Services of Northern Ontario, your work is primarily in Thunder Bay and the surrounding communities?

Mr. Peter Gravelle: We have a facilitator worker out in Kenora, and so she does work in the district. We're also close to hiring someone to work for a year up in Sioux Lookout. But our catchment area goes from the Manitoba border to Wawa, so it's a huge area—and, of course, Kenora. The bulk of our work is here but we do work in the district.

Mr. Howard Hampton: Would you say the bulk of your work is here, the bulk of your service work?

Mr. Peter Gravelle: The bulk of our service and the bulk of our staff. But we know that there are lots of individuals who have brain injury and addiction problems in the district, so it's not inconceivable to think that you could have several people working out in the district. So we're not as well-served as we could be.

Mr. Howard Hampton: So people who, say, live in Kenora, or Red Lake or Sioux Lookout: What kind of services do they get?

Mr. Peter Gravelle: Well, we have a full-time worker who has a caseload, and referrals go to her. We have a neuropsychologist who comes in there every two weeks and works with her. But it's like anything: She certainly could have more support. More workers could be working with her.

Mr. Howard Hampton: That's a lot of highway for one person to cover.

Mr. Peter Gravelle: That's a lot of highway.

Mr. Howard Hampton: You do a lot of fundraising as well, or you have done—or associated with BISNO, there's been a fair bit of fundraising in local communities. In terms of the services you provide and the funding you get, do you have a breakdown of where that funding comes from? How much of it's through fundraising etc.? How much is through—

Mr. Peter Gravelle: We have proprietary services, so a lot of our money will come through insurance, WSIB. We'll work with individuals who've been injured on the

job, so some of our funding comes from that. Of course, other funding comes from the ministry.

We don't actually fundraise a lot in terms of working on our budget. I would say that's much smaller. More of it comes from our proprietary program and from the minister. So to answer your question, I'm not exactly sure what the exact breakdown is.

Mr. Howard Hampton: To be fair, I've often felt that what have been listed as fundraising activities have actually been raising-profile activities for the services that you provide, but oftentimes that's how you get people to participate.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Liz?

Mrs. Liz Sandals: When you say the ministry, it's the Ministry of Health or Comsoc or—

Mr. Peter Gravelle: Ministry of Health.

Mrs. Liz Sandals: Okay. Could you describe what would happen to a child who, given the age issues—for the sake of argument, a 14-year-old who has attempted to hang themselves. When they come to you, they've got addiction or mental health issues; quite probably, especially given the last presentation we heard, FASD. Can you walk us through what support would be offered to that child and what your piece of it is, what programming you do?

Ms. Nicole Spivak-Nigro: Generally, it would start with the application and our intake coordinator and myself, because most referrals now come to our community programs. We're going to look at who is involved in that person's life, and first of all, do they want to be here? It's one thing to be a teenager; it's another to be a teenager with a brain injury and fetal alcohol spectrum disorder. We cannot necessarily always differentiate some of the challenges of building rapport. How well-supported is that person? So if there is FASD and mental health, especially with past suicide attempts, where are they located?

1530

Generally what we'll do is hold what we call a stakeholder meeting, so we'll want to invite children and youth services, whether it's the Children's Centre Thunder Bay or counselling services; the school, if they're involved, if there's an IEP; mental health services; and then find out who can be involved in what capacity with this individual's life. Because we will know right off the bat that although we can identify all of those needs, we're still going to have to prioritize them, and we will know we're not going to be able to meet them. And the best way to try to support this person, especially at that young age, is to find out who is going to be there. So the quicker the services can begin, and the more comprehensive, really, depends on the community partnerships that will be part of that person's life.

With fetal alcohol spectrum disorder, it's not a criterion for our services. We've had a few individuals with FASD in service, but the reason they were in service was because they had also sustained an acquired brain injury, an event that was sentinel, that we could say,

"Okay, we have the cognitive overlap." Trying to differentiate between the development and then the event is very different, and that's where we really rely on the developmental services to do that—also, because sometimes they can be more enduring as far as flux in support when it comes to supportive living, with group homes or supported employment.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Go ahead.

Mr. Peter Gravelle: There's no specific pediatric ABI funding. That certainly would make a huge difference in terms of helping out families who have children who get an acquired brain injury.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Peter and Nicole, for coming—a great presentation.

Mr. Peter Gravelle: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thanks for your time and attention.

BRENDA ATWOOD

KAREN MILLER

LINDA KACHUR

The Chair (Mr. Kevin Daniel Flynn): Okay. Our last presentation of the week is Brenda Atwood. Come on forward. Everybody sits in the back row, just like in school.

Interjection.

The Chair (Mr. Kevin Daniel Flynn): In church, yes—church, school.

Make yourself at home, Brenda, and introduce the people you're with. You've got 20 minutes.

Interjection: This is Brenda.

The Chair (Mr. Kevin Daniel Flynn): Okay, good.

Ms. Brenda Atwood: We are a family group.

The Chair (Mr. Kevin Daniel Flynn): You're a family? Wonderful. You've got 20 minutes. You can use that any way you see fit. If you would prefer to leave some time at the end, I know that that usually works out pretty well for any questions or answers. It's all yours.

Ms. Brenda Atwood: Thank you for giving us the opportunity to voice our concerns as family members of a drug addict. My goal here today is to give a face to the overwhelming devastation of having a life disrupted by substance abuse.

Addictions are said to be a family disease because of the impact they have on the entire family. Our entire lives become as chaotic and horrendous as that of the person with the addiction. Often our lives seem to revolve around one crisis or another. In many instances, drug addiction is associated with crime in order to finance the drugs. Many families live with not only the stigma of a family member's addiction but often are the victims of crimes committed by their own loved ones.

Research alludes to the fact that there is a high correlation between mental illness and drug addiction. It's a commonly held belief that there is stigma towards the mentally ill, but that pales when it comes to the

stigma towards drug addicts. It's very difficult not to internalize that stigma as a family member.

I know all too well what the common perception is toward a drug addict and their families. Far too often, a drug addict is perceived to be from a family that doesn't care, that used poor parenting, that are substance abusers or criminally minded, or something else that just crawled out from under a rock. So we suffer that stigma also.

Our lives and our families carry the shame and humiliation. A lot of self-blame happens, especially with parents of an addict. And what help is there for those families?

So when your possessions have been stolen, not by a mysterious stranger but by the person you love, or when an elderly parent or grandparent gets shoved around because they don't want to hand over money for drugs, or when a young parent is fearful because of a spouse's addiction, what help is available?

Police services far too often offer little help in family situations. Often, if police are called and a child is in the home, children's aid is called, and now there's the added stress of being investigated by children's aid, through no fault of your own, and dealing with a loved one's substance abuse.

So what help is there? Most services are available 9 to 5, not the most beneficial time to be of any help. Services such as ConnexOntario, DART and other 1-800 phone numbers are pretty well only referred for the drug abuser when they're straight and able to navigate horrendous systems to attempt to get help themselves. Without being totally sarcastic, maybe you really should try to access some of those services before more money is spent on those types of services.

Family groups should not have to struggle for existence, nor should they face stigma. A family group, for me, is the only place where I feel free to talk about the struggles of an addict in the family, the place where there's understanding, where there's no judgment passed and where more than a few tears are shed. A family group, for me, is the only place where I felt free to talk about the deep devastation of the impact of an addiction on my life, the only place where I got some strength to cope.

As a local family group, we have tried to be involved with CAMH on a few occasions. We have tried to give feedback to the Ministry of Health's strategic plan for mental health and addictions, but it seems that service providers want to talk about the families, not talk to the families. To further illustrate that fact, as a family group we met at the local treatment centre, but we were given our notice to vacate. They were busy building a new treatment centre, but I'm afraid a new building will not make their service any more effective. When it comes to treatment services, perhaps it would be wise to reflect on that old adage that if you keep doing things the way you've always done them, you'll continue to get the same results. Simply put, the 28-day, 12-step program with little to no follow-up does not work. It's really time to start looking at what are best practices in treatment and then make those services available to all.

The prognosis for a drug addict is not good. Untimely death by suicide, drug overdose, drug-related illness, accidental death while under the influence or death as a result of violence are the most prevalent causes of death. For many of us, we've accepted this as inevitable because hope has gone out the window as we've seen our loved ones battle addictions and lose that fight.

Ms. Karen Miller: Good afternoon. My name is Karen Miller. I also just want to thank you for allowing us to speak this afternoon.

The Chair (Mr. Kevin Daniel Flynn): There's some water there if you need it.

Ms. Karen Miller: Just a deep breath. As parents of an opiate addict for eight years, we've encountered too many situations during this time that we were ill equipped for, uneducated about and emotionally and mentally exhausted from. This is the main reason I'm here today, to briefly educate you on what we as a family have to go through with a drug addict. Unless you've been in our situation, you will not be able to fully comprehend even a small portion of what we go through, but the encouraging part of today is that you're here and you're willing to listen to us.

I'd like to begin at the point in the addict's drug career when they think they want to quit using. This is the point where they say, "Where do I go from here?" When the addict comes to the point of brokenness and has an honest desire to be clean, they—the addict—and their family are faced with trying to find out where to start, and one of the many questions is, do we start with an agency and, if so, which one?

When the desire is there, time is of the essence, and the intake process can take up to three months, which is an extremely long time in the eyes of an addict. Please bear in mind that the addict is usually extremely stressed out with high levels of anxiety because, depending on if they are withdrawing, most are unable to focus and express themselves completely and precisely. The agency process includes the actual application, the assigning of a counsellor, the interview, the processing of the results of the interview, and appointments to gather all necessary information to be able to refer to the treatment centre. They need help today. There's an urgency that in so many cases is not being met, and then what happens? The addict is back on the street and he's using, stealing, cheating, dealing, lying, denying and manipulating. They're driving the family crazy. I'm not sure if any of you have ever had to, but my husband and I had to sleep in front of each of our doors so that our son would not go out at night to get high as we're trying to keep him straight in order to get into treatment. It's not normal to have to sleep in front of your doors, but when you're looking at three months to get an addict into a treatment centre, it's totally ridiculous. Your life becomes chaos. It's surrounded by the drug addiction.

1540

Drugs are an instant gratification to the addict, and patience isn't in their vocabulary. There's no immediate help for the drug addict; unlike if you were a cancer

patient, a kidney patient or you had a heart attack and the help is readily available. It's just a drug addict.

Another question is, do you go to the hospital? When we first started our journey with our son, you had to be suicidal to be admitted to the adult mental health ward of Thunder Bay Regional Hospital. We told him to tell them he was suicidal in order to get into that hospital to be able to medically withdraw. The hospital is not well equipped to handle the complexity of addiction. The stigma that is attached to being an addict or an addict's family is huge, even from within the medical community. Some people have never even told their immediate family members that they, their spouse or their child is a drug addict because of the stigma that's attached. But if you've been fortunate enough to be admitted into the hospital, you're then faced with the medical withdrawal, which is a blessing compared to withdrawal on your own. Again, if you've ever experienced a loved one who is an addict writhing, vomiting, just in complete agony, and at the same time having to have diarrhea because of the fact that they're trying to withdraw themselves, you stand by totally helpless because there is absolutely nothing that can be done.

The most understanding caregivers are those who have been affected themselves by someone close with an addiction, otherwise you can become involved with some very cold-hearted people. When your patience and tolerance are at an all-time high level as a parent and you're talking to someone who cannot understand why they keep doing this to themselves, it's like, "You are just book smart. You have never been there. Do you know what an addiction is?" They don't understand, once the addict has become clean, why they can't just stay clean. As you've probably heard numerous times today, relapses happen, and they don't happen just once; they happen over and over again.

We here in Thunder Bay are facing a high shortage of psychiatrists. Locums are the only ones who tend to be available, and medication, once it's administered by the locum, can only be changed, reduced or increased by the locum psychiatrist. So if they're only coming in every three months or so—in the case of my son it was two months—you have to wait. The family doctor does not want to do anything that the locum psychiatrist has prescribed, so he won't adjust any type of medication.

Very brief assessments are being done, and often there are underlying mental health issues and concerns that are not identified, treated or followed up on. Sadly, it's the addict who is being released too soon from the hospital. They usually don't have anyplace to go. They have no food. They don't even know where they're going to be in an hour or so. To wait for days, weeks, even months for treatment just seems too far for them. This is the addict we're talking about. How long do you think they can stay clean on their own? Again, when we were going through this with our son, we drove for hours. The only thing that would get him past the desire to go and get high was going for a car ride. We saw northwestern Ontario to the limits. Our greatest fear was getting stopped at a red light

and him jumping out of the vehicle. It's just unfathomable the hold that this drug, which is the opiates, has on them.

Halfway houses are another option—again, a lengthy process to get through the doorway. Some addicts, where are they? They've burnt all their bridges; they no longer even have families that care about them. They only have one thought, and that is, "Can I stay straight for three months before I get in there?" or "Where is my next high coming from?" Probably, nine times out of 10, they go and get high because they can't see any further than right now. Their distorted thinking is that they might be dead tomorrow so "Let's get that one last high in."

Treatment options are very limited and not nearly enough for the demand. Often, it is not recognized that relapse does happen. Hospitals see an addict, law enforcement sees a criminal, but we see our loved ones. Assessments for concurrent disorders need to be more in-depth.

Again, getting into a treatment facility means another waiting list, paperwork, jumping through hoops, referrals, everything—three months to a year. Some communities will not even take an individual from another community.

The 28-day program at the Sister Margaret Smith hospital is definitely not long enough. I think by the end of 28 days, the fog is just starting to clear in their heads, and then they might be ready to begin the process of learning new tools for a sober life and moving forward with treatment.

But not only is there a lack of treatment facilities for the addict, facilities for families are even worse. There is hardly any support whatsoever. We searched out numerous agencies. We hit lots of closed doors and confused doors because too many times they had never heard of parents calling to ask for help for themselves. How could we help them if we didn't know what we were dealing with?

I happened to call the Sister Margaret Smith hospital and was put in touch with a counsellor who was very willing to sit down with us, my husband and I. She answered our questions. She tried to relieve some of the frustration that we were experiencing. But after a couple of sessions, we were still left to pick up the pieces of a fractured family and try to resume a normal life, whatever that was.

The Chair (Mr. Kevin Daniel Flynn): Karen, I'm assuming you're going to split this approximately three ways.

Ms. Karen Miller: Yes, and I'm coming to the end.

The Chair (Mr. Kevin Daniel Flynn): I'm just telling you that you've got about four minutes left as a group. I'm prepared to extend that a little bit because you're our last one, but it probably is time to summarize.

Ms. Karen Miller: Thank you. I don't know if you've seen this. This just happened to come into my mailbox today, which I thought was a wonderful coincidence. It's called Talking with Your Teen About Drugs. It's great; it's very comprehensive. It's put out by the government of Canada. The only thing is, there is nothing about

opiate use in here. I think you've heard, probably a number of times today, about the high incidence of opiates in northwestern Ontario and the devastation it can cause. I suggest that something else get included or a new booklet get made, because opiates are a huge problem, and they need to be recognized as that. Thank you.

Ms. Linda Kachur: I promise I won't be long. My name's Linda Kachur. Thanks for letting us speak today. I'm here on behalf of our family group. Our family group is a non-profit group which has been in existence for a challenging three years. I say challenging because resources are not readily available to our community like in southern Ontario.

The district of Thunder Bay has the highest incidence of drug addiction in the province of Ontario. Today, our group would like to make a little bit of a difference in our community by presenting to this select committee the following recommendations.

Immediate specialized services should be available to our loved ones suffering from this disease of addiction. I call it a disease of addiction because I don't like the word "addict." When a person who suffers from addiction realizes they need help, they need it immediately. They do not need it the next day or the next week.

Sister Margaret Smith Centre has built a brand new treatment facility, which is our only treatment facility, with no increase in beds. And as you've heard, it's only a 28-day program. What are the statistics of the success rate of this 28-day program? A longer program, three to six months, with a more structured and disciplined program, teaching new life skills, credit counselling for budgetary and financial matters, and second-stage supervised housing would be an asset and very beneficial to the person with the addiction for successful recovery.

Services need to recognize that relapse happens—documented as part of the recovery process—and allot for this in the program.

Our loved ones or someone else's loved ones suffering from this horrible disease of addictions have become victims.

Mandatory treatment for persons convicted of committing a crime as a result of addiction—also probation and parole orders monitored should include urine testing.

They also need to adjust the services, not to punish the person but to provide quick re-entry to get them the same help they need.

Increased medical support needs to happen, such as psychiatrists, as you have heard, and other medical professions with training in the complex health needs of a recovering addict.

Support for family groups such as access to educational resources would be of benefit.

Housing for addicts before and after recovery is limited. For example, Three C's have gone above and beyond for families in need. However, Three C's funding and beds are limited.

That's all I have to say.

The Chair (Mr. Kevin Daniel Flynn): You did a wonderful job. It was nice of you to all get together and make one presentation as opposed to three.

We have to be on a plane at 4:30, but if there's anyone who wants to ask any questions, we probably have a couple of minutes. Sylvia?

Ms. Sylvia Jones: I just want to thank you for coming. If there was any doubt that what we are doing here with the select committee—you certainly reinforced it. Have faith that we're not going through a process. We actually want to make change because we are hearing from family members who are trying to help their loved ones.

The Chair (Mr. Kevin Daniel Flynn): Anybody else? Howard?

Mr. Howard Hampton: One of the things that we've heard over and over again—and I know you were sitting here earlier—and now I think we're hearing it from you, the family members, is that for a variety of reasons, whether you're somebody who's suffering from schizophrenia or drug addiction or FASD, it's just damned hard to access anything. Do you have some recommendations on what needs to be done? We can have all kinds of programs, strategies and initiatives, but if people can't

get to them, it seems to me we're just blowing money out the door. Do you have any advice?

Ms. Brenda Atwood: Wait times have to be reduced—quicker access to programs. Too often, it's everybody else's problem. If you're involved with the police: "You're the person with the addiction." If you go into a hospital: "No, it's addictions. It's not hospital-related." I think there has to be far more understanding across the board from a whole lot of services—and also services just being far more timely. A person with an addiction is not cured overnight, so if they go through one assessment and they relapse, why start with an assessment again? You know what the problem is.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today. We have a plane to catch at 4:30, otherwise we'd sit and chat with you. We have to take that shack down over there, too, before we leave, apparently.

We're adjourned to Toronto next Wednesday afternoon.

The committee adjourned at 1554.

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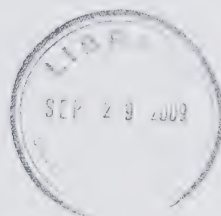
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Wednesday 16 September 2009

Journal des débats (Hansard)

Mercredi 16 septembre 2009



Select Committee on Mental Health and Addictions

Mental Health
and Addictions Strategy

Comité spécial de la santé mentale et des dépendances

Stratégie sur la santé mentale et
les dépendances

Chair: Kevin Daniel Flynn
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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

SELECT COMMITTEE ON
MENTAL HEALTH AND ADDICTIONSCOMITÉ SPÉCIAL DE LA SANTÉ
MENTALE ET DES DÉPENDANCES

Wednesday 16 September 2009

Mercredi 16 septembre 2009

The committee met at 1607 in committee room 1.

The Chair (Mr. Kevin Daniel Flynn): If we could call the meeting to order—we don't have any sub-committee business to deal with. This is our first meeting since we've come back from Ottawa, Sudbury and Thunder Bay.

MENTAL HEALTH
AND ADDICTIONS STRATEGY

SCHIZOPHRENIA SOCIETY OF ONTARIO

The Chair (Mr. Kevin Daniel Flynn): Our first expert presentation today is from the Schizophrenia Society of Ontario. Vani Jain and Mary Alberti are with us. Thank you very much for joining us today. You've got half an hour, and you can use that any way you see fit—I see you're equipped to do that. If you'd leave a little bit of time at the end for some questions and answers, that would be great as well, but that's entirely up to you.

Ms. Mary Alberti: Thank you very much. We would like to formally thank you for the opportunity to be here. We at the Schizophrenia Society endorsed the creation of this select committee early on in December. As you know, the issues you're working on are very near and dear to our hearts and to the population we serve. We also applaud your consultations across the province and the work you've done to date, and thank you for that.

We're going to walk you through our presentation today fairly quickly, because we do want to leave an opportunity for questions and answers at the end of the presentation.

First, a little bit about the organization: Our mission at the Schizophrenia Society of Ontario is to improve the lives of individuals and families affected by schizophrenia and psychosis. We do this through our programs and services, which support, educate and empower individuals and families and promote community awareness. We advocate on behalf of individuals and families, we work with other organizations and we promote early intervention. We also support and advocate for research. I know that many of you have had the opportunity to participate on different things with us around the table at the Schizophrenia Society as well.

We are a grassroots organization. We were founded in 1979, and our grassroots commitment to the community continues. We were founded, actually, by a group of

families who had individuals with schizophrenia in the family.

We could not do the work we do today without volunteers across Ontario, many of whom are family members and individuals with schizophrenia. I think that through your select committee consultations, you've probably heard from many of our volunteers across Ontario.

Over the past 30 years—it is our anniversary this year—we have grown to be a provider of significant services to families and consumers through eight regional programs across Ontario, which are all designed to meet local community needs.

We have a very strong history of advocacy and policy work, and have been leaders in the mental health field in advocating for services that address the needs of families. We have currently identified access to treatment as our key advocacy initiative.

Our organization differentiates between mental health and mental illness. Our focus is on providing a voice for the needs of people with serious and persistent mental illness, and that's what our presentation is going to focus on today.

A little bit more about the organization: Our operating budget is just over \$2.6 million, of which 24% is supported through government. The rest we raise on our own. We're able to carry out the work with a complement of 25 staff positions and 340 volunteers across Ontario.

In our last fiscal year, the organization invested in programs and services that had the following results: We served just over 4,700 individuals through our family education and support program; just over 1,300 individuals with schizophrenia were supported through our education program; and we reached over 3,000 individuals in our community advocacy program—we have an estimated reach of over two million in the public relations and media work that we do.

A need for a mental health strategy: A very strong and comprehensive mental health strategy that addresses the needs of our population is needed in a very timely fashion. One in 100 people will develop schizophrenia over their lifetime. The onset of early psychosis and schizophrenia is most often between the ages of 15 and 24 years of age. As schizophrenia and psychosis impact families and communities, ultimately many individuals in Ontario are impacted by this serious mental illness.

The current system or systems that are attempting to serve individuals with severe mental illness are under-

funded and currently not well coordinated. This often results in services that are strategically and not equitably delivered across Ontario, and a lack of services and supports in general.

Given the limited time we have today, we're going to focus on two priority areas for people with serious mental illness. One is access to treatment, and the other, health and justice issues.

Access to treatment: The information we are going to present to you today has been based on nine cities that we visited, with over 350 people participating in community forums. We've been advocating on the issue of access to treatment since we began this process. Our efforts culminated last year in these forums in hearing from consumers, families and service providers about the barriers they face in accessing treatment and the solutions that they felt would make a difference in improving the system. We have included a complete copy of this report in your package.

We've identified basically three pillars when we define access to treatment: psychiatric treatment, which refers to medical models of treatment such as care by a psychiatrist or hospital-based care. It also includes medication, one of the cornerstones of treatment for schizophrenia. We must ensure that there's open access to all medications on the provincial formulary. Community services such as case management, ACT teams, counselling and peer support are also vital in the treatment process. Finally, addressing the social determinants of health such as housing, income and employment support must be protected. These three pillars need to work together.

What did people tell us across Ontario when we looked at barriers? We know that people with schizophrenia and their families face many barriers to accessing treatment services and supports. The full list of barriers are in your package as well, but we want to walk through some of them for you.

Lengthy wait times are a major concern. The average wait time from referral to treatment by a psychiatrist is 17 weeks. In rural parts of the province, this number is even higher. We find this length of a wait time an unacceptable statistic. Emergency room wait times are another concern, which the Schizophrenia Society has addressed, and we have put our full policy paper in your package, which talks to this.

In terms of the system capacity, consumers and families face many issues. We see this in hospitals where even psychiatrists have told us that they feel pressured to discharge patients prematurely simply because there are not enough psychiatric beds. Overall, the lack of services is a major problem, particularly in non-urban centres where we see that even more.

We also learned about the gaps which exist in our current system. Many people told us they couldn't access services when they really needed them. For example, one might have issues that are too complex for one program but not serious enough for another. The consequence is that many of our people fall through the cracks.

Community-based services are usually only available on weekdays. People who need help in the evenings or on weekends have nowhere to go and just turn to an emergency room.

Finally, there is a lack of outpatient follow-up care for people who are discharged from hospital. This makes it difficult for people to transition back into the community and receive services and supports that they need. In terms of stigma and discrimination, one of the biggest concerns we heard was discrimination by health care providers. Many people told stories about doctors in their communities who would not take on patients with complex mental illness.

The social determinants of health are also extremely important. We must not forget that mental health is influenced by more than just the provision of health care. Many people with serious mental illness are dependent on the Ontario disability support program for income. Unfortunately, ODSP income is a maximum of \$1,020 per month for a single person. We must ask, could any of us around this table afford to pay for shelter, food and other basic needs with just over \$1,000 a month? There's also a serious lack of supportive and affordable housing in this province, leaving many people to wait on lengthy wait lists for housing.

Employment, which is significantly important for people with schizophrenia in contributing to their quality of life and their own value and self-worth, has had a very negative impact on people in their recovery process. Employment is almost virtually impossible for people with schizophrenia to access.

In terms of system integration, our system is currently designed in silos whereby people get their health care from one system, their income support from another system, and their community services from yet another system. None of these systems seem to speak to each other nor do their policies align with each other in many aspects.

Another major barrier to accessing treatment is difficulties with system navigation. The families we work with tell us time and time again that they didn't know enough about the signs and symptoms of psychosis and schizophrenia to know there was a problem. Oftentimes our illness area is misdiagnosed and unrecognized. Once the issues had been identified for their children and for their family members, people did not have enough awareness of where they could actually go for help. And just remember again, oftentimes you're waiting for a long time before you're actually able to see a psychiatrist. So when we talk about issues of early intervention and early identification, they are compromised because of that.

1620

The final barrier to accessing treatment we will mention is our current laws governing mental health in Ontario. While these laws have been designed to protect people with mental illness, there are ways in which they pose challenges in helping people get into treatment. One of the concerns we hear most often is the difficulty in getting help for someone who doesn't believe they have a

mental illness. This is especially true at the early intervention stage where there are many difficulties in helping the individual to get an initial assessment, and part of the aspect of having a severe and persistent mental illness like schizophrenia is that oftentimes you have a real lack of insight that you do have the illness.

There are elements of our privacy laws which make it difficult for people to get the proper treatment. We have included in our package a submission regarding amendments to the Personal Health Information Protection Act, which provides more detail on that. We understand that this is a complex issue with no easy solutions, but we wanted to flag it for the committee as it's something we hear about often.

So that represents what we heard from about 350 people across Ontario who are living with severe and persistent mental illness like schizophrenia, their family members and helping professionals. I'm now going to turn it over to Vani Jain, who is the manager of our policy and community relations program and the head of our justice and mental health program, to talk about criminalization and mental illness.

Ms. Vani Jain: Thank you for having us here today. SSO has been addressing issues related to justice and mental health for several years. However, work in this area began more formally about two years ago, when we established our justice and mental health program. This program has been designed to support families of people with mental illness who are in contact with the law, while promoting change in mental health and justice.

We initiated this program because there really was a high demand from families who had a loved one whom they were supporting through the criminal justice system and needed assistance and system navigation and information on how to advocate and support their loved one through the process.

We also have a strong background in policy work in this area, addressing issues such as taser use on people with mental illness, police record checks and how they affect people with mental illness specifically, as well as, most recently, the issue of deportations of people with mental illness. This deportations project examines the immigration consequences of criminalization—and it's quite complex to get into, so we've included a description of that in your package as well.

What our experience has shown us is that, while there have been many improvements in the area of mental health and justice over the past several years, such as the implementation of mental health court diversion programs, mental health courts and safe beds, for example, these have made a huge difference, but we really do still have a long way to go.

When we use the term "criminalization," what we're talking about is a criminal justice or legal response to behaviour related to mental illness. This is evidenced clearly by the disproportionately high number of people with mental illness in our jails as well as people who come into contact with the police on a daily basis.

In our view, there are two key causal factors behind criminalization. One is deinstitutionalization and the

resulting lack of access to treatment. Over the past 40 years, people have been moved from psychiatric hospitals into the community, which is a great policy and it's great for people with mental illness. However, the community sector was not developed at the rate that it needed to be and people are still unable to access treatment and supports in the community. So in our view, the plan for deinstitutionalization was really never completed, leading to poor access to treatment. Because many people are not able to access treatment and supports in the community, their symptoms often are exacerbated and they are at higher risk of going into psychosocial crisis.

Our civil commitment laws are also an issue, because the criterion for civil commitment is "an imminent risk of harm to self or others." Oftentimes, when people reach the point of dangerousness, they're actually coming into contact with the police rather than the mental health system. The result is a revolving door where people cycle in and out of the system without having their issues meaningfully addressed.

There are a few key issues that I'll touch on briefly. The first and most important is probably that, while we have had all of these great new programs and policies developed in the area of mental health and justice, they have not really addressed the root cause of the problem, which is access to treatment. Our efforts in this area should not only be reactive; we must also look at how to improve access to treatment so that people don't come into contact with the law in the first place.

Another issue is the people who are not diverted out of the criminal justice system and end up in jail. There's basically a category of people whose offences are probably too serious to make them eligible for diversion, but they don't meet the criteria to render them not criminally responsible, which is the inability to understand the nature and consequences of your actions. So, this middle ground of people often ends up in jail.

For these individuals, access to treatment in correctional facilities is a major, major issue, and we know that our correctional facilities in Ontario do not have the capacity to address some of the serious mental health issues that the inmates present with. When these individuals are ready to be released, discharge planning is often not sufficient, leaving them without proper arrangements for community support. This can increase the risk of relapse and reoffending. Sometimes individuals are not accepted into community services because they have complex criminal records, and I'll go into that in a little bit more detail later.

In terms of our recommendations, we have some concrete recommendations for the committee on how to improve access to treatment services and supports specifically, as well as some recommendations on how to solidify the mental health strategy and improve mental health policy over the long term. We've tried to prioritize our recommendations in the interests of time. I'm sure we could sit here for an entire day and talk to you about all the things that could be changed to improve the system.

In terms of improving access to treatment, our number one suggestion is to increase access to psychiatrists in the province. One of the things we're looking at is how to increase the number of psychiatrists who are practising in the province. In 2004, which is the latest statistic we could find, there were only 13.1 practising psychiatrists per 100,000 people, and that number is highly concentrated in urban areas. I'm sure you've heard through your travels that when you're looking at non-urban, rural northern communities, there are sometimes one or two psychiatrists practising if you're lucky.

Currently, only 5% of medical graduates choose psychiatry as their first choice for residency, and that's due partly to the stigma of practising psychiatry. Also, what needs to be recognized is the compensation levels. Psychiatrists earn 15% to 50% less than other specialty areas, and obviously that is a disincentive for practice in the area. We need to increase incentives for practising psychiatry in the first place as well as practising in northern and rural communities specifically.

Another way to increase access to psychiatrists in non-urban areas is to make better use of telemedicine, specifically telepsychiatry. I know you've already heard from the Ontario Telemedicine Network, so I won't repeat those recommendations. However, we do support the suggestion to expand telemedicine for mental health across the province as a way of increasing access to psychiatry.

Another approach to be examined is shared care. Again, the gentleman from the Ontario Telemedicine Network discussed this. Basically, you would have a health care practitioner, such as a nurse practitioner, doing the face-to-face client work with the individual with a mental illness but with guidance from a psychiatrist from afar. That allows the individual to receive access to treatment in a more timely manner and closer to home.

These are just some of the examples of innovative approaches or models that should be examined when we're trying to improve access to psychiatric care.

Our suggested priority for improving access to community-based care is to focus on the most at-risk, high-needs individuals. In our experience, people with really complex cases—that is, people who are dealing not only with serious mental illness but also issues of poverty, homelessness, addiction and sometimes criminal histories—are the individuals who have the most difficulty accessing services. Part of this is due to the capacity of community agencies to address the needs of these complex clients, but we can't ignore the stigma and discrimination that occur even within our sector as well.

In cases where a particular agency does not feel equipped to provide service to a high-needs, at-risk client, we need to ensure that a system is in place to refer that individual to another agency for service. People should not simply be turned away because they can't be helped by that particular agency without an alternative.

In terms of funding as well, a priority should be put on this population. Models such as assertive community

treatment, intensive case management and highly supportive housing should be expanded and prioritized for those who need them the most, those with the most complex needs.

1630

Another way to improve service provision for at-risk, high-needs individuals is to improve the links between community services and institutions such as hospitals and jails. In times of limited resources, priority should be put on those who are most at risk of relapse or reoffending due to lack of community supports, and intensive supports must be provided to these individuals during their transition into the community—so really, eliminating that gap, those cracks that people fall through.

As mentioned earlier, the social determinants of health play a crucial role in mental health recovery. Eighty per cent of people with schizophrenia face barriers in entering the workforce and are dependent on ODSP. That's a huge, huge number of our population. Unfortunately, this program actually works against recovery in practice. If we are to improve access, we really need to see major reforms to ODSP. One of our first recommendations is, as stated in the poverty reduction strategy, that a social assistance review must be conducted, and this review must go beyond minor changes and really make substantive changes to the program.

Some of our suggestions, based on the demands of the ODSP Action Coalition, which is a group that we are a member of, are to:

- raise ODSP levels to cover the real cost of living;
- index ODSP rates to inflation;
- simplify the application process;
- provide sufficient staff to support people with mental illness and other disabilities through this process;
- eliminate barriers to employment supports; and
- increase access to education and training.

We need to change this from a program that keeps people in the depths of poverty to one that really helps and supports people in their recovery.

I'll turn the presentation back over to Mary for our last two recommendations.

Ms. Mary Alberti: There are a couple of recommendations we have around infrastructure development and how you ensure that a mental health strategy will have longevity in Ontario and that a strategy will actually be carried out and can be implemented. The first is to restructure the government responsibility for mental health. As Michael Kirby from the Mental Health Commission of Canada has mentioned to you and stated in his presentation, one of the major impediments to strategic planning and delivery of mental health services is the lack of a single-point person or body responsible for mental health.

Currently, as we know, the Ministry of Health and Long-Term Care takes on most of the responsibility for this area. We know that mental health is not the only health issue that we face, but we do know that mental health cuts across all government departments and it impacts many people. Coordination and buy-in from

different ministries can only go so far. What we need is a minister responsible for mental health and a distinct body within the government whose sole responsibility is mental health. We are proposing a secretariat to deal with mental health and a body that would deal with that.

A model you would be familiar with that we have examined is the Ontario Seniors' Secretariat, which you've already heard of in your consultation process. Here you have a minister responsible for the issue and an assistant deputy minister who reports to them. You have dedicated staff who develop policies and programs and meet the needs of a target population and who advise in policy across government. The creation of a specialized department responsible for mental health issues in Ontario that could coordinate the efforts of all the ministries that are involved in this issue is vital.

Our second recommendation for you to consider is to enshrine mental health strategy into legislation. While past governments have shown interest in mental health and have commissioned report after report to provide recommendations for system improvement, none of these recommendations were adhered to when a new government came in. What is needed is long-term, ongoing commitment that will extend beyond one government's mandate.

We would like to use the Poverty Reduction Act as an example for you. In May, the provincial government showed its commitment to poverty reduction by passing Bill 152, the Poverty Reduction Act. We recommend that a similar act be created based on a mental health strategy. This act would include specific targets and indicators and measure how well the province is doing in addressing mental health issues in Ontario. It would also ensure that subsequent governments are required to re-examine the mental health strategy and provide a report on progress, to engage in consultations with key stakeholders during this review process and report publicly on the results.

In closing, in our recommendations for infrastructure, what we are looking for is that a strategy actually come to life, and that implementation is key, that in Ontario the issue be taken very seriously and that we do see some change, because mental illness impacts many people in Ontario.

We thank you for the opportunity to present to you, and we'll be open for questions.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much. You've left us about six minutes, so we'll get about two from each of the parties. Christine or Sylvia?

Ms. Sylvia Jones: I'm glad to see that you've raised the privacy issue because, as you can imagine, many families have talked to this committee about how that's a frustration for them. I obviously haven't had a chance to look at the recommendations, but I wonder if you could highlight some of the solutions you see, because so far we haven't had anybody come forward with solutions.

Ms. Vani Jain: Again, the legal aspects of this are very complex. We looked at, first of all, very minor changes. One of the issues that families face is in sharing information with the health care provider and being

concerned about what the repercussions of that would be should their family member find out. So we looked at strengthening the wording around when a health care provider should share that information with a patient and when they may take the safety concerns of the family into consideration when making that decision.

Another thing that we looked at was clarifying the privacy act and how it's used by health care providers. We found that there are a lot of people who provide health services who actually go beyond the requirements of the privacy act, when it comes to sharing information with family members. So one of the things we recommended was doing more education with health care providers around what the actual limitations are versus the perceived limitations.

The Chair (Mr. Kevin Daniel Flynn): France?

M^{me} France Gélinas: I was interested in that question, but I'll try to pick a quick one. You've talked about stigma and discrimination. We've heard lots of people pointing to health professionals as being the worst culprits—and the examples of people with severe mental illness having a tough time finding a family physician and the consequences of that. There are new models out there of interdisciplinary care, whether we talk about family health teams or we talk about community health centres. Is there something out there in primary care that works better for your members, for people with schizophrenia?

Ms. Mary Alberti: Maybe I can start with that and then Vani can add. Yes, I think when we look at health teams where individuals with schizophrenia feel comfortable and feel that they can trust the team they're working with—the primary care program at a place like Mount Sinai is an example that might work very well.

I think the other component of it, education of primary care practitioners, is key. Schizophrenia is not something that a primary care practitioner would deal with on a day-to-day basis or have real knowledge of, but we feel there is very limited knowledge about the illness and the health-related consequences of schizophrenia. As an example, a lot of people with schizophrenia would have diabetes, would suffer from metabolic disorder, a lot of the effects of medications.

I think we speak more on how we can educate people about social inclusion and how we can have good health practice for people affected by schizophrenia, so looking at models where—I think the trust factor for many of our people is very important. The ability to go to one location to have a lot of their health needs met is very important; that they're not travelling or going to different parts of a city is also very important.

The Chair (Mr. Kevin Daniel Flynn): You have about 20 seconds left to do the other half, Vani.

Ms. Vani Jain: Oh, no, it's okay. We can go on to the next question.

The Chair (Mr. Kevin Daniel Flynn): Are you sure? You want to move on?

Ms. Vani Jain: Yes.

The Chair (Mr. Kevin Daniel Flynn): David or Bas.

Mr. David Zimmer: Just last week, the very distinguished psychiatrist Oliver Sacks wrote an article in the New York Review of Books entitled "The Lost Virtues of the Asylum." He uses the word "asylum" in its Oxford Dictionary meaning; that is, a place of refuge, a place of protection and a place of sanctuary.

He makes this statement: "The last 15 years or so have seen a new generation of antipsychotic drugs, with better therapeutic effects and fewer side effects, but the too exclusive an emphasis on 'chemical' models of schizophrenia, and on purely pharmacological approaches ... may leave the central human and social experience of being mentally ill untouched."

He makes the point that the pharmacological treatment of it is not enough. There also have to be places of refuge, sanctuary and protection where people can live out their lives, because although the drugs may control it, there's no real protection, no real humanity. Would you agree with his statement?

1640

Ms. Mary Alberti: That fits very nicely into our access-to-treatment campaign and identifying the three pillars of treatment, and what we would identify as that. I think we can't negate that certainly anti-psychotic medication is very important, as well as other medications, but community and social supports are also very important.

Mr. David Zimmer: Then he goes on to make the point—I just want to get this in—that one of the difficulties is that the legal community, or the legal world—I'm a lawyer—has stepped in and has all sorts of barriers in place that really prevent the hospitalization or institutionalization of people who really need that kind of sanctuary and protection. What would you do about all the legal types who are causing difficulties?

Ms. Vani Jain: I'll address that—another legal question. It is a challenge, and our mental health laws are really meant to balance individual rights and freedoms with public safety. I think we've made great strides in trying to achieve that balance, but yes, there are ways in which our mental health laws actually prevent people from getting treatment, especially when they're in a situation where they may not know they need help at the time. As Mary mentioned, lack of insight is an issue that people face.

From our perspective, we don't have the answers right here and right now, but one thing we would recommend is doing a review of our mental health laws and looking at how well they are actually serving people with mental illness, and looking toward perhaps other ways of designing those laws.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Vani and David. Bas, if you've got a very, very short one and then Christine. We're just going to extend this a little bit.

Mr. Bas Balkissoon: Okay. I have a very quick one, and if you can't answer it today and could send us input, that would be really great. You basically said that the system for dealing with mental health is uncoordinated. I'm wondering, if you look across the province, do you

have an idea for the committee as to how we would restructure it? If you don't have the answer today, I'd be willing to get your input later on in writing.

Ms. Mary Alberti: We'd be pleased. We can send something with our thoughts about that, absolutely.

The Chair (Mr. Kevin Daniel Flynn): That's wonderful. Thank you. Christine?

Mrs. Christine Elliott: I don't have a question but rather just a comment. I'd like to thank you both very much, Mary and Vani, for your presentation today but also for your very early support of the creation of this committee. In many ways, you're partly responsible for us being here today, so I'd really like to thank you very much for your ongoing efforts and all of the wonderful work you're doing, especially, as David mentioned, with respect to the issue of mental health laws. We have heard from a significant number of families in our hearings across the province, and it is something we are looking for more input on. So if you can point us in a direction that will help us make a determination and some recommendations, that will be helpful. We would really appreciate that.

Ms. Vani Jain: Absolutely.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Christine. Thank you very much, Mary and Vani, for coming today. Great presentation.

ONTARIO COLLEGE OF FAMILY PHYSICIANS

The Chair (Mr. Kevin Daniel Flynn): Our next presenter is Dr. Jan Kasperski, CEO of the Ontario College of Family Physicians. It's wonderful to see you again, Jan. You always hit the good issues.

Ms. Jan Kasperski: It's Ms. Kasperski, because Ms. Kasperski is a registered nurse.

The Chair (Mr. Kevin Daniel Flynn): That's right. I'm sorry.

Ms. Jan Kasperski: The Ontario College of Family Physicians is run by a nurse.

The Chair (Mr. Kevin Daniel Flynn): That's right. I knew that, and I blew it.

Ms. Jan Kasperski: Just for everybody's information, the Ontario College of Family Physicians is a chapter of the College of Family Physicians of Canada. Our college has received a federal charter in order to develop the standards of practice for both the practising family physician and for the education of family medicine residents, so we work really, really closely with all 17 medical universities across Canada to accredit their programs, and family medicine residents sit the exam in order to be licensed in the province of Ontario. We are truly the educational body.

In Ontario, the Ontario College of Family Physicians works really closely with all six medical universities to ensure that our residents here in Ontario receive a really superb education, but our college spends a great deal of its time and effort in continuing professional develop-

ment to ensure that family physicians stay as current as our residents.

I think it's really important for the select committee to recognize the fact that 80% of medical care in this province is delivered by family physicians, and that includes 80% of the mental health care that is delivered in this province. Thirty per cent of the patients presenting to a family physician are in that office because of mental health and addiction issues.

Family physicians deal with patients through their whole lifespan, and we're not just talking in the mental health arena of patients who have severe persistent mental disorders. People have emotional, social and mental health and addiction problems throughout the whole of their lifespan.

Our patients become very distressed when they can't be parents. They worry terribly during the first trimester of their pregnancy, and they suffer tremendously when their fetus is lost. The sleepless nights and anxiety during the last trimester lead to an overwhelming happiness at the beauty of the world's most precious baby being born. But it can quickly turn to maternal blues or to postpartum depression. Did you know that there is not one setting in this province in which a mother who is in a crisis postpartum can be bonded with her child? We separate them. We send the baby home; we bring the mother into hospital.

Family doctors are there when our parents are worried about autism or childhood mental disorders or learning problems or behavioural problems. We deal with childhood obesity, acne, bullying and all the trials and tribulations that lead to adolescent angst, eating disorders, alcohol and drug use, promiscuous behaviours, and arguments and violent episodes, which we're seeing in this city in spades.

We support couples when they're having marital difficulties, and we're the first to know when there's violence in the home. We help them through midlife crises, and we're there when they're experiencing empty nest syndrome, which I'm experiencing myself.

We're identifying and intervening very early when Alzheimer's disease is suspected. We care for our patients with dementia in their homes and in long-term-care facilities, and we do it as best we can. We support their loved ones. We try very hard to ensure that the patients have the best quality of life, as long as possible.

We comfort our patients when they've lost their spouse, parent or precious child. We are the doctors who are working in the emerg departments when a patient is brought in by police after a call from a family member who fears their loved one is suicidal or homicidal.

When the diagnosis is severe persistent mental disorder or they are addicted to drugs or alcohol, or they're doubly diagnosed with both, which is often the case, we are frequently left on our own to deal with the patient and the family members without the support we need from the system. This is especially true for those of us who practise in the far remote north, trying desperately to meet the needs of our First Nations people.

We do all of this and much more in a system that is fragmented and hard to access, and that lacks the people with the knowledge and skills to provide evidence-based care.

What has the Ontario College of Family Physicians done to help our members? We established the Collaborative Mental Health Care Network. This is a province-wide program that pairs psychiatrists with GP psychotherapists to mentor family physicians, who receive just-in-time advice as well as formal education to increase their knowledge, skills and, just as importantly, their confidence in being able to provide excellent mental health and addiction care. It has proven to be such a successful model that it has been established as a permanent program, funded by the Ministry of Health. We have been invited all over the world to help other ministries of health set up similar programs, but I bet none of you know about it.

The Alzheimer's physician education strategy has been modelled after the collaborative mental health network, but it pairs geriatric medicine and psychiatry specialists with family physicians who have taken our third-year residency program in care of the elderly. It supports family physicians to care for patients with dementia and their families from that first stage, when they begin to show signs of mild cognitive behaviour, right through to end of life.

1650

The medical mentorship for addictions and pain has teamed pain specialists with addiction specialists and methadone prescribers. They assist family doctors in dealing with the care of patients with intractable pain and the sequelae of the use of opioids, such as addiction. This project has led us into the realm of drug diversion. We're working closely with the police, with pharmacists. We now know that opiates are the street drug of choice, and we have a great social issue to deal with in that realm.

Lastly, we have worked hard on developing family health teams, with social workers and mental health workers embedded in the teams, to assist with the 30% to 35% of the patients in our practices who need mental health services. With practice supports in place, with guidance and advice from our specialists, family doctors are much more willing to take hard-to-serve patients into their practice. These patients may receive care in the mental health service arena, but they lack primary care, so their physical health is neglected. They are ripe and ready for chronic disorders. Their eating behaviours, their lack of exercise, their smoking like chimneys and their medications all lead to early onset of major chronic disorders. We want them in primary care.

What are our recommendations to you? By the end of the term of office of this government, we will have 200 family health teams in place, but that's not enough. Every person in this province deserves to have their care needs met in a family practice with inter-professional team members to really meet their needs. We need to invest, and invest heavily, in the primary care sector. Patients do not want to be seen in an environment labelled "psychia-

tric hospital" or "clinic," "addiction outpatient clinic" or "methadone clinic." They want to be cared for where they're comfortable: their medical home. We want to bring the expertise to those family practices rather than sending the patients to the black box of psychiatric care. We suggest you support shared care in mental health programs and bring psychiatrists and social workers to our practices. We certainly hope you support our collaborative care model.

We need to create a single entry point into an integrated mental health and addiction program. It is just too hard to find all of the services that are out there, and patients deserve to have easy access. When a family doctor can't find them, they can't. We need to create a Cancer Care Ontario for the mental health sector, one that undertakes research to identify best practices and evidence-based care and measures every service provider to ensure that they're providing high-quality care. We are often uncomfortable referring because we just don't know the quality of care, the methodologies and the philosophies in the programs that are out there. We need to do a better job of measuring and ending up at the end of the day convinced that we're able to give the best care possible.

We need to invest, and invest very heavily, in the early years, zero to six, when the resilience to all kinds of chronic disorders, especially mental health, can actually prevent them. We need to put public health nurses back into our schools to give better access to our children and adolescents during their formative years.

We need to address childhood poverty and, indeed, poverty in general. At a minimum, we need to ensure that everyone has a roof over their head and sufficient food to eat.

We need to shore up employee assistance programs by making every employer responsible for creating a healthy workplace. It should be a priority in Ontario.

Our health care system was built on the principle of equity; that is, the most care for those most in need. It is not equal care; it is equitable care—most care for those in need. Patients with mental health and addiction problems are some of the most needy people in this province, but instead of providing them with equitable access, we don't even provide them with equal access. That great Canadian philosopher Rex Murphy once said that the Canadian health care system is cherished by the public because it is the best expression of Canadian values. He went on to say that nowhere in the health care system do we see these values translated into action more fully than in the family doctor's office.

Thank you so much for inviting me to meet with you today. I'd be happy to answer any of your questions.

The Chair (Mr. Kevin Daniel Flynn): Jan, thank you very much for coming. It was a great presentation. We're going to start with France. Unfortunately, we've got about a minute and a half each, so if we could make these brief.

M^{me} France Gélinas: Thank you very much for an excellent presentation. I value the work that the Ontario College of Family Physicians has done in mental health.

I would be interested, if you could share with us a little bit more, in who you see being part of the shared-care model in mental health.

Ms. Jan Kasperski: The shared-care model actually got its start here in Ontario, and we should be very proud of the successes. It has rippled all across Canada.

In the shared-care model, psychiatrists, social workers and mental health workers go into a family practice, and with the family doctor they assess, in conjunction with the patient and family, the patient's needs; develop a care plan; and then leave that care plan for the family doctor to oversee, along with the support of a social worker. That model works really, really well.

The Collaborative Mental Health Care Network has modelled that type of support, but at a distance. Our psychiatrists tend to be really well established in the larger cities. Throughout the rest of the province, access to psychiatry is very, very limited. Getting in to see a psychiatrist here in Toronto is hard enough, but trying to get in to see one in the rest of the province is difficult. So we have paired GP psychotherapists with psychiatrists to mentor family doctors at a distance—so by e-mail, by teleconferencing. They get just-in-time guidance and advice so patients don't wait to get care. As soon as the problem is identified, the knowledge and the skills to be able to look after that patient are delivered to the family physician.

The Chair (Mr. Kevin Daniel Flynn): I'm going to have to cut it off there. Jeff?

Mr. Jeff Leal: Thank you, Ms. Kasperski, for a very good presentation. I'm from Peterborough, so we have great experience with family health teams in my community, which has been the model for the rest of the province.

Ms. Jan Kasperski: I was part of your steering committee.

Mr. Jeff Leal: Absolutely. I thought I'd get that plug in today.

We have a family health team model that was developed for many communities, particularly in southern Ontario. I'm wondering if you've given some thought to developing a family health team model and the various components of that to serve our First Nations in particular. We have geographic challenges. We had the opportunity to visit Sandy Lake a couple of weeks ago. It's very isolated. Have you given some thought to the components of a family health team model that may work directly and in partnership with our First Nations community, bearing in mind that the traditional healing methods have to be part of that family health team, along with our traditional approaches to medicine delivery?

The Chair (Mr. Kevin Daniel Flynn): Jan, this is going to have to be almost a yes or no.

Mr. Jeff Leal: I'm sorry. My preamble was a bit long, but I wanted to set the table on this one.

The Chair (Mr. Kevin Daniel Flynn): Take your time, but we do have to be brief.

Ms. Jan Kasperski: We have been working with the chiefs in order to address some of the issues around

mental health and addiction—opiate use—in our First Nations communities. Again, the only medical supports tend to be our family physicians flying in. So shoring up, on site, in professional teams is where we should go.

The Chair (Mr. Kevin Daniel Flynn): Christine?

Mrs. Christine Elliott: Thank you for your presentation. We have not heard about the Collaborative Mental Health Care Network in committee before. You were right when you said we probably had not. Can you tell me when it was established and whether it's fully rolled out across the province?

Ms. Jan Kasperski: It was established in 2000. It was evaluated in 2004. It demonstrated that family physicians who are part of the network tend to keep their patients within practice, so it has been really cost-saving. They don't end up being just shipped off to emergency or sent to psychiatric services. It has built communities. The family physicians start to really know what community services are out there and reach out to them.

When I said there will be only 200 family health teams by the end of the next couple of years—in actual fact, there are lots of virtual teams out there, where smart people have been able to find ways of building virtual teams. That's probably the model that we're going to end up being able to use: most cost-effective in using the services that are already there, but bringing them into practices rather than out.

1700

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today, Jan. Great presentation, as always.

Ms. Jan Kasperski: No problem.

DIANE DE CAMPS MESCHINO

The Chair (Mr. Kevin Daniel Flynn): Our next and final presenter today is in perinatal mental health, Diane de Camps Meschino, provincial liaison. If you'd come forward, Diane, make yourself comfortable.

Interjection.

The Chair (Mr. Kevin Daniel Flynn): That's the first hug ever in Hansard, I think.

Like everybody else, you get 15 minutes. You can use that any way you see fit. If you could leave a little bit of time at the end for any questions, that's entirely up to you, but it seems to work well when that happens.

Dr. Diane de Camps Meschino: That's my plan. Thanks very much.

I'm Diane de Camps Meschino. I am a psychiatrist. I currently work at Women's College Hospital as the leader of a program called the reproductive life stages, which is reproductive mental health. I cannot tell you how thrilled I am to learn about this committee and how thrilled I am to be here, and I first of all want to thank you for that. In terms of who I am, I'm extremely committed to our health care system, I'm extremely committed to improving our health care system, and as such, I do an awful lot of volunteer work in terms of team building and program building.

I'm here to tell you not that the population I serve is more important, but really to bring it to your attention. The population we serve and our program is across the lifespan. We deal largely with mood, anxiety and psychotic disorders which present primarily during reproductive life changes; that could be premenstrual, pregnancy, postpartum, pregnancy loss and the menopausal transition. The bulk of our patients are perinatal, pregnant or postpartum or loss. The reason for that is these patients have the greatest urgent need. They are undoubtedly the sickest, they get sick very quickly and they need urgent services, so they fill most of our spots.

In terms of the overview of what I'm going to tell you today, I'm going to go over some statistics to tell you why this population is important to know about and to look at; the impact of these illnesses on mothers, fetuses, children and families; I'm going to tell you a little bit about what a coordinated systems model would look like and identify some gaps in the current system. I am here, in fact, representing the province. When I received the invitation on Monday to present today at 5 o'clock, I e-mailed my colleagues across the province and said, "How do you feel about me acting as your liaison at this meeting?" I got responses immediately from my colleagues all across the province saying, "Yes, please," so I'm here representing this whole group of us that do this work.

Why am I here pitching the pregnant and postpartum population? For women, this is the highest time in a woman's life where they would get a severe mental illness. So if they already have depression, then depression recurs very typically in pregnancy or postpartum, but not mildly; it occurs in a severe form. It is a very high time for relapse of bipolar; 75% chance of relapse of bipolar in the first two weeks postpartum—untreated bipolar. Same with anxiety and obsessive-compulsive disorder. You will probably be most familiar with the media—can you hear me?

The Chair (Mr. Kevin Daniel Flynn): That's the problem: We can hear you almost too well. These are great mikes, and you can sit back a little bit. What happens is they pop if you get too close, so you can relax and you can almost walk around and talk, they're so good.

Dr. Diane de Camps Meschino: That's great. So, is that better, then?

The Chair (Mr. Kevin Daniel Flynn): That's great.

Dr. Diane de Camps Meschino: Thank you. Just getting back to my slides here: Of the women who become ill during the pregnancy and postpartum period, about a third are a first onset of mental illness and about two thirds are a recurrence. It's an ideal time for intervention, prevention and promotion. The reason for that is that mothers or mothers-to-be are amongst the most receptive patients I have ever encountered. I've worked in family practice and I've worked in many areas of psychiatry, and there's nothing that's gotten me as fired up as working in this particular area. Moms want help and they will seek help on behalf of themselves and of

their children. They're receptive and they're highly motivated. They will do whatever it takes to get well and keep their children well.

Just in terms of who I'm here representing, I work with the Ontario college of family practice, as you could see by my reconnecting with Jan. I work with Best Start Hubs, public health, Hamilton, and I was instrumental in helping set up the perinatal psychiatry programs in Sudbury and the North Network, Ottawa, London, the Niagara region and Toronto. I led the setup of the program here. I represent clinicians, researchers and educators.

The trouble with our current system is that we are swamped. I'm sure you have heard that from everyone who has sat in this spot. Waiting lists are clearly an issue; you don't need to hear more than that. But the impact that this has on our patients is that we triage according to priority, so only the very sickest patients get seen and only the sickest patients get service. That means we're not intervening early for the other patients. We have to wait until they actually get very sick before we can treat them.

I'm sorry the graph is small; I can send you the PowerPoint electronically if it's helpful. This is just a slide on depression; it doesn't include bipolar, anxiety or OCD. Just depression alone, we're looking at 13,000 to 26,000 women per year who get the most severe form of postpartum or prenatal depression and another 46,000 to 80,000 women who get moderately severe depression; 70% to 80% of women with depression who are treated recover. The remainder require ongoing care.

How's my time?

The Chair (Mr. Kevin Daniel Flynn): I'm using the BlackBerry to do it. You've got about eight minutes left.

Dr. Diane de Camps Meschino: Okay. I'm going to have to fly.

The next slide I've got here regards maternal deaths. Mental illness is the most common complication of pregnancy and the most common complication of postpartum, bar none. If you look at this graph—this data is from the UK—it accounts for the greatest number of maternal deaths up to one year postpartum.

I was introduced once by, "Now that we've solved all the difficult things in terms of complications of obstetrics and labour and delivery, we can deal with the soft things." I responded with, "Since when is suicide soft?" And I would say that here. This is something that is not properly dealt with or known. We don't have stats in Canada on this.

In terms of the impact on untreated mothers, if they're pregnant, they become sicker. We're dealing with frequent substance abuse. There are labour and delivery complications. There's evidence that untreated illness has an impact on the brain of the fetus, with long-term consequences including mental illness and cognitive and language development. This is fairly new evidence, but the evidence is mounting in study after study after study; it's convincing.

In terms of the infant and the child, we also know that with postpartum depression, even if the mother is not

depressed in pregnancy, there are frequent long-term implications for language development, cognition and mental illness and also increased physical illness.

1710

I'm not going to go over all of my slides. I'll leave them to you, but I want to say that mild symptoms and moderate symptoms can be dealt with very well in the community as long as there's expert care to back them up. We don't have enough experts. There's a very small number of us, and we're trying to handle the problems for the whole province. The severe symptoms need to be dealt with by experts in reproductive mental health because the data and research on the subject change so rapidly that there is no possibility that one could be a specialist in another area and keep up with the material in this field.

Necessary components of a system would include screening, identification, creating care pathways, and community treatment, including public health, home visitors and family health teams. Within specialist care we need out-patient programs, which is the one thing that we have. An intensive day treatment program would be very helpful to keep patients out of hospital. We need an in-patient program where we cannot separate mothers and babies—that's a bit of a luxury that's well-developed in other countries. We desperately need a database. We do not have a Canadian database. We're relying on countries around the world—Australia, the UK and the United States. We need policy and we need standards.

The next slides really illustrate what an integrated continuum of care would look like, but I don't want to go over that in detail for you. Let me just stress that some of our major gaps include that illnesses during this period are underdiagnosed and undertreated—that's both addiction and other mental health problems. We do not have a coordinated system for screening, identification and treatment. We don't have preventive programs for high-risk women and teens. We do not have services that well accommodate the needs of diverse, marginalized, refugee or new immigrant families—and teens and immigrant families are at particularly high risk. We have inadequate expertise. Those who are expert are really expert, but there aren't enough of us.

We do not have a parenting program for mentally ill parents that deals with both the child and the parent. Led by Jean Wittenberg, we have rolled out an excellent program that helps mentally ill parents parent, but it does not deal with the mental illness of the parent. The international movement in this area now recognizes that these programs, while they're fantastic, have paid inadequate attention to the parent's mental illness, in this case maternal mental illness.

Barriers to care and access include language, culture and distance to travel. Many of our moms come from great distances, through ice storms and snow storms, with multiple children. It's a crazy way to deliver care to these poor women who are also mentally ill.

Child advocacy problems: People are terrified of their children being taken away. I just met with children's aid

today. I want to reinforce that the program that has family meetings with transparency, where we are seen as helpful, not punitive, is going to be very important in terms of women who are pregnant and post-partum accessing care.

I'll stop there, and I welcome your questions.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today. That was a great presentation. As we've travelled the province, we've learned a lot about fetal alcohol syndrome and also touched on the issue of post-partum depression, but this is probably the most thorough presentation we've had on the perinatal population.

We've got a very short time for questions but probably time for one from each of the sides. Is there anybody on this side? There isn't? We can go right to Christine and Sylvia.

Ms. Sylvia Jones: Just really quickly, thank you for your presentation. Jan previously mentioned—I'm not sure if you were in the room—

Dr. Diane de Camps Meschino: I was.

Ms. Sylvia Jones: —how there was currently no access for mothers to be treated with their children. You've also highlighted it as one of your issues. Is there any access to that program where a mother could be treated without having the child either stay at home or be elsewhere?

Dr. Diane de Camps Meschino: The reason I know Jan is that I put a proposal together with a steering group that you will find in your package here as an outline. It's really a comprehensive program for the entire province. Getting it to the government has been very difficult. It has been reviewed by the Toronto Central LHIN favourably, but of course money is the issue.

Included in that proposal were a couple of in-patient beds for mother and baby. Mount Sinai did volunteer two of their in-patient beds where mom and baby can be admitted together, but there are a lot of issues around liability, and at this point they do not have the staffing to take care of the baby. That would have to be provided by the family.

Ms. Sylvia Jones: Thank you. Two beds.

The Chair (Mr. Kevin Daniel Flynn): France?

M^{me} France Gélinas: You mentioned that you did basically a screening of your waiting list and provided treatment only to the most severe cases. Is there anything out there you can offer for early intervention and for people that don't meet the "very sick"—to get care with you?

Dr. Diane de Camps Meschino: We prioritize because we have to, because these patients are often suicidal and have homicidal thoughts regarding their infant, so we have to respond to that. I've spent a lot of time putting educational programs together and have travelled the province with the Ontario College of Family Physicians. Unfortunately, we get small numbers of people out. So, we're trying to build expertise in family practitioners and the family health teams, and that would be enormously helpful. Other than that, I've also worked with Toronto public health, trying to enhance their expertise so that they can do as much monitoring for us in the community as possible. You've asked me a question about the beds. I think that's an issue, but I think a much greater issue is the community. If you don't have all tiers of your system together, it's going to fail, and ours is failing because we do not have community resources. We don't have enough people to transfer our patients to once they get well enough to leave our program. We need family doctors; we need public health; we need home visitors who have enough expertise that they could manage these patients. We're delighted to provide the backup.

The Chair (Mr. Kevin Daniel Flynn): That's wonderful. Thank you, Diane. Thank you very much for coming today and speaking on behalf of your colleagues—and yourself, of course.

Dr. Diane de Camps Meschino: Thanks very much. If you want this in an electronic format so you can see the slides more easily, I can send it.

The Chair (Mr. Kevin Daniel Flynn): If you would e-mail it to the clerk, that would be wonderful.

Dr. Diane de Camps Meschino: That's great; will do.

The Chair (Mr. Kevin Daniel Flynn): Thank you, members of the committee, for attending today. This meeting is adjourned.

The committee adjourned at 1715.

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Select Committee on Mental Health and Addictions

**Mental Health
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Comité spécial de la santé mentale et des dépendances

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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

SELECT COMMITTEE ON
MENTAL HEALTH AND ADDICTIONSCOMITÉ SPÉCIAL DE LA SANTÉ
MENTALE ET DES DÉPENDANCES

Wednesday 23 September 2009

Mercredi 23 septembre 2009

The committee met at 1600 in committee room 1.

SUBCOMMITTEE REPORT

The Chair (Mr. Kevin Daniel Flynn): We can call to order, ladies and gentlemen. Our 4 o'clock presenter is here. We're going to deal with the report of the subcommittee from September 10 first. Does that need to be read into the record? Would somebody like to read the report of the subcommittee into the record? You'll find it attached to your agenda.

Mrs. Maria Van Bommel: I will do that. Your subcommittee on committee business met on Thursday, September 10, 2009, to consider how to proceed with site visits to First Nations communities, and recommends the following:

- (1) That the committee separate into two groups.
- (2) That the first group—Mr. Leal, Ms. Gélinas, Mr. Balkissoon, Ms. Jaczek and Mrs. Elliott—visit Curve Lake First Nation and Alderville First Nation on Friday, October 9, 2009.
- (3) That the second group—Mrs. Van Bommel, Mr. Flynn, Ms. Jones and Mrs. Sandals—visit Oneida Nations of the Thames and Six Nations of the Grand River on Wednesday, October 14, 2009.
- (4) That the committee clerk and a research officer accompany both groups.
- (5) That the committee clerk, in consultation with the Chair, be authorized, prior to the passage of the report of the subcommittee, to commence making any preliminary arrangements necessary to facilitate the committee's proceedings.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Maria. Are there any comments? Jeff?

Mr. Jeff Leal: Yes, Mr. Chair. There's a change here. We've been working very closely with Ms. Gélinas to accommodate a very important event in her family's activities. So we are going to make our visit in the afternoon of Thursday, October 8, starting at 2 p.m. in the afternoon. We are going to, I think—because I know the logistics reasonably well—we can fit in three: Curve Lake First Nation, Hiawatha First Nation and Alderville First Nation. Mr. Balkissoon and I have arranged with the whip's office for us to be absent that afternoon. It was hard negotiations, but we were able to do it. So we can accommodate a couple of requests.

The Chair (Mr. Kevin Daniel Flynn): Very good. Great news. And I understand we'll be adding one to our tour, perhaps?

Mr. Jeff Leal: Yes. I just haven't—

The Chair (Mr. Kevin Daniel Flynn): Go ahead.

Mr. Jeff Leal: Sorry, Mr. Chair. We are working with the clerk and my office to make the appropriate logistical arrangements.

The Chair (Mr. Kevin Daniel Flynn): Super. Maria, we'll be adding a location to our tour, perhaps.

Mrs. Maria Van Bommel: There is a possibility of also adding another one, and possibly even a joint meeting at Six Nations with a neighbouring First Nations.

The Chair (Mr. Kevin Daniel Flynn): Okay. We'll make allowance for that, then. France?

M^{me} France Gélinas: I have never felt so bad in a long time—everybody flipping over their House duty and everything. I cannot get out of House duty on the eighth. I cannot go on the eighth. I was able to talk to Christine yesterday, and she couldn't make it on the eighth either.

The Chair (Mr. Kevin Daniel Flynn): Oh, okay.

M^{me} France Gélinas: Didn't it sound like a good idea at the time? So we're back to having to find a new date. We'll talk after the meeting today.

The Chair (Mr. Kevin Daniel Flynn): How we could leave it, perhaps, is that you still want to visit the three communities—is that right?

M^{me} France Gélinas: Yes.

The Chair (Mr. Kevin Daniel Flynn): So why don't we leave it at "a date to be determined by the group"?

M^{me} France Gélinas: Okay.

The Chair (Mr. Kevin Daniel Flynn): And then we don't have to meet again as a subcommittee.

Mr. Jeff Leal: Mr. Chairman, we can reconvene at some stage.

The Chair (Mr. Kevin Daniel Flynn): Yes. But just your group can get together and decide how you would want to do it.

With those changes: All those in favour of the subcommittee report? Those opposed? That is carried.

MENTAL HEALTH
AND ADDICTIONS STRATEGY
FRANK O'HARA

The Chair (Mr. Kevin Daniel Flynn): As I said, we have a gentleman here who's from our 4 o'clock dele-

gation, and don't worry, I'll add all the time you need onto it.

We have before us the Family Council and the Secret Handshake. We've got Frank O'Hara with us. Frank, you've got 10 minutes to make your presentation. You can use that time any way you see fit. If you want to leave some time at the end for any sort of a discussion with the group, that would be great also, but entirely up to you. Welcome.

Mr. Frank O'Hara: Great. Thank you very much. I'm here not to talk particularly on behalf of those two organizations, although I am closely associated with them; I'm here to, you might say, plead my own case.

I guess cumulatively, with two sons having schizophrenia, I've got maybe 60 years or more of experience dealing with the system, and I could go on for a long time about that. But one of the serious problems that I recognize and I'm trying to do something about—I've put together a PowerPoint presentation that I propose to give to people in clubs like the Kiwanis Club or whatever—anyplace where someone will listen to me, because I think there's an important message to get out about the stigma associated with mental illness and what we might do about it.

Interjection.

Mr. Frank O'Hara: Unfortunately, we can't get the—you can't hear the audio unless you were very quiet, I guess.

Mental illness—the stigma associated with it and what we can do about it. The first thing is, how common is mental illness? I'm going to whip through these things very quickly because most of you are probably quite familiar with the statistics. One in five people everywhere, not just in Canada, have mental illness: schizophrenia, 1%; major depression, 8%; anxiety disorder, 12%; one in 10 Canadians over 15 years of age report symptoms of abuse from alcohol and other drugs; 43% of individuals with a substance abuse disorder also have diagnosable mental health problems; and 3.8% of adults in Ontario have moderate to severe gambling problems.

1610

You can't read this, and it's so small at the bottom I can't read it myself. I got those stats from CAMH.

We're having another little video here. Maybe you can hear the audio this time.

Video presentation.

Mr. Frank O'Hara: The cost to society: Every day, 500,000 Canadians miss work because of psychiatric problems. Mental illness is the number one cause of disability in Canada, accounting for 30% of disability claims and 70% of total costs. The Ontario economy loses \$34 billion a year.

Interjection.

Mr. Frank O'Hara: Thank you. Families suffer emotionally and financially.

Interjection.

Mr. Frank O'Hara: Oh, just a minute. I'll reshoot that.

Are we spending enough? Approximately 1.6 million Canadians have an undiagnosed mental illness. Only 5% of the total health budget goes to mental health, less than most comparable countries. Ontario's per capita investments in community health are much lower than in BC and Quebec and well below the national average. I think of myself, as an Ontarian, being number one. I think it's disgraceful. Only Saskatchewan and Newfoundland and Labrador spend less per capita than Ontario.

Only 40% of assertive community treatment teams in Ontario have the required psychiatrist.

The streets of Toronto—let's look at this. Seaton House: Maybe some of you are familiar with it. I'm more familiar with it than I'd like to say. There are 434 beds, but all the people in that place and in similar places in the city have to be out on the streets during the day. They are not allowed to stay there. There's no place for them to go. We wonder why there are so many people wandering around the streets. It's because 83% of the homeless in Toronto are mentally ill.

Video presentation.

Mr. Frank O'Hara: I guess we had Santa Claus out there for a little while, did we?

Support: The Centre for Addiction and Mental Health—everyone's aware of that, I'm sure, a very major organization in the province.

There are a couple of the organizations with whom I've worked. I produced a website. I happen to know something about websites, so I donated my time and my computer to doing a website for these two organizations. This is the one for the family council, and there's the story about it—at least that's the first page, what's going on. For anyone who wants to find out what's going on with this organization, the family council, there's all the information that's available. The schizophrenia peer support group: I won't take the time to show their website, but I've also produced a website for them. Other organizations for whom I have not done their website, a couple of them are below. But there are lots of organizations associated with mental illness.

Some people will say, "Well, you know, there aren't all that many people with"—Or if they don't think about it, they think there aren't that many people who have mental illness, or if they have, "Why should we be so concerned?" Well, here's a list of some people, just a drop in the bucket of the number of people who have contributed significantly to world economy and culture, who all had some form of mental illness. The list could go on and on.

So, what can we do? Well, every time we run into the stigma, let's do something personally, individually, about it. We don't stand for somebody making negative remarks about coloured people and various people, things that used to go on in our society. We still accept the stigma of mental illness. Support adequate housing—that's really important; support mental health charities; volunteer.

By the way, on the subject of volunteering, last spring I phoned up CAMH to volunteer. I have a criticism of

their website. It wasn't obvious how I could—it would seem to me that one of the first things on the website should be, "Here's how you can volunteer. Click here." On the websites that I've developed, I'm making that a priority.

The last word—this doesn't have any audio. The website that's mentioned at the bottom there and this particular video were developed by young people in London, Ontario. There you see their ages and their names. I think they've done a fine job.

Video presentation.

Mr. Frank O'Hara: And one final little jolt: It's not the person; it's the illness.

The Chair (Mr. Kevin Daniel Flynn): Frank, that was excellent time management. You left four seconds. I thought you were going to hit it right on the head there for a minute. With all of the moving around you were doing, I was quite surprised you could get it all in in ten minutes. Thank you very much for your presentation—very well received.

Mr. Frank O'Hara: Does anyone have any questions?

The Chair (Mr. Kevin Daniel Flynn): Unfortunately, we don't have any time for questions, but I think you got your point across. I know the committee pretty well now, and I think you were very clear in your presentation.

Our next presenter today, then, is from the Mental Health Legal Committee. We've got Marshall Swadron, who is the chair of the committee. If you'd like to make yourself comfortable, Marshall, there's some water and, I would think, some clean glasses over there if you need any.

Mr. Marshall Swadron: As long as there are no meds in the water, I'm fine.

Interjection.

The Chair (Mr. Kevin Daniel Flynn): Oh, I'm sorry. Frank, I cheated you. I'm sorry, Barry, could you just step aside for a minute? Frank, I'm sorry; I cheated you out of some time. I want to apologize, and I want to give it back to you.

Mr. Frank O'Hara: I realized that, but I'm too nice to say anything.

The Chair (Mr. Kevin Daniel Flynn): You and I would get along. I would do the same thing.

Let's start with Christine and Sylvia. Let's have maybe one question each.

Mrs. Christine Elliott: Thank you very much, Mr. O'Hara, for being here today and raising the issues that you have.

If you don't mind, if we could ask you a few questions about your experience, because as a parent you have a lot to share with us. We've heard from some parents that they experience frustration in not having any kind of input, not being listened to, necessarily, by some of the mental health professionals and not being able to seek the help they need for their children when they can see that they need some treatment and there's nothing they can do to assist with that. Could you please comment on that?

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Mr. Frank O'Hara: I have experienced every kind of thing, from wonderful attention to none. Let me just pick one on the negative side.

I had a son who was in the hospital in Whitby. As you know, there are all degrees of schizophrenia. His was quite serious. He'd been there for some time, and they asked him one day if he'd like to leave. He said, "Sure, I'd like to leave." They gave him \$100 and a ticket on the GO train to come to Toronto, which he did. They never informed me. They just sent him to Toronto. I found out when I went out to visit him a week or so later.

So after about six months, some good Samaritan picked him up on the street and drove him down to 999 Queen. This was a number of years ago. At first he gave another name, but finally he gave his proper name and then somebody contacted me. I took him back to the hospital in Whitby and they said, "He's been discharged. We can't take him back here." I said, "I don't give a damn whether he's been discharged or not. You're taking him back."

If he hadn't had somebody like me to plead his case then and various other times, he would have been in deep doo-doo, believe me. He would have been walking the streets, as he did for six months and damn near starved to death.

The Chair (Mr. Kevin Daniel Flynn): Thank you. France?

M^{me} France Gélinas: It was interesting. You have such a breadth of knowledge and hands-on experience with severe mental illness, but yet you chose to talk to us about fighting stigma, which I applaud you for. I think it takes courage. You basically put out a four-point plan, simple but effective. Have you seen it work anywhere else? If we follow those four points, will it make a difference? Will it work?

Mr. Frank O'Hara: No, I'm carving a new road here. I haven't shown this presentation to anybody else. I've just developed it recently. I hope to get some results, but I don't know of anybody else who's done something similar. There's the odd video that you can get on YouTube—I downloaded these videos. But in terms of somebody launching a crusade, I don't know of anybody.

M^{me} France Gélinas: But you picked those four points, I guess, because you feel that if we try this, it may work.

Mr. Frank O'Hara: I'm open to any more that you might suggest. I'm wide open. Those are the only ones that I thought of. They're not scientific. After careful thought I figured: What can you do about this thing? Not a lot. As an individual, I'm doing my part, I think, to just make people aware.

M^{me} France Gélinas: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Frank. Unfortunately, our time is officially up now. So thank you very much for coming, and thanks for your patience.

MENTAL HEALTH LEGAL COMMITTEE

The Chair (Mr. Kevin Daniel Flynn): We'll move on now to Marshall. You're all settled in. You, like Frank, have 15 minutes, and you can use that any way you like. If you leave some time at the end, maybe we can get into some questions and answers.

Mr. Marshall Swadron: Thank you. I appreciate it very much. My name is Marshall Swadron. Suzan Fraser is also present here, but I'll be speaking on behalf of the Mental Health Legal Committee. I'm a lawyer with a six-lawyer firm in Toronto. I've been practising for just over 20 years, and much of my practice is in the area of mental health law.

The Mental Health Legal Committee is a group of lawyers and community legal workers practising in the area of mental health law. It was established in 1997. The committee has advocated for the rights of consumers of mental health services in many forms. Our approximately 60 lawyer members appear in all of the mental health-related tribunals, and the two main tribunals are the Consent and Capacity Board, which is a provincial body that deals with issues relating to involuntary committal, capacity with respect to treatment, capacity to manage one's finances and other issues, including community treatment orders—another body before which we appear regularly is the Ontario Review Board. This board is established under the Criminal Code and deals with issues of detention and reintegration into the community of persons who are found either unfit to stand trial or not criminally responsible in respect of offences under the Criminal Code for reason of mental disorder.

The Mental Health Legal Committee has intervened in five significant Supreme Court of Canada cases, as well as in others. Next month, the case of Paul Conway will be heard by the Supreme Court of Canada, and the Mental Health Legal Committee will be intervening. That case, in particular, relates to whether the board that deals with—the Ontario Review Board, but these boards are of course across the country, because they are under the jurisdiction of the Criminal Code—can give remedies under the Canadian Charter of Rights and Freedoms.

The committee has made submissions in respect of a number of legislative initiatives, including Bill 68, which was the amendment of the Mental Health Act in 2000, which put into place community treatment orders and also expanded the involuntary commitment criteria under the Mental Health Act; also, legislation in Bill 135 that was the amendment with respect to the use of restraints in public hospitals.

The Mental Health Legal Committee has been involved in inquests into the deaths of patients in psychiatric hospitals. This year, we also made submissions with respect to amendments to the Coroners Act, which ultimately were enacted, that require inquests into the deaths of persons who die while in restraint in psychiatric detention.

We receive no funding, and we operate on the basis of the volunteer contribution of services by members of our

committee. I want to tell you this specifically and categorically because not all those who come before you will be able to do so: that we receive absolutely no funding from the pharmaceutical industry—my effort at humour. I submit that it is important, and the influence of the pharmaceutical industry on mental health policy is one that we must be very mindful of. I hope, toward the end of this discussion, in the time that I have, while leaving some time for questions, to be able to speak to that issue in the context of screening, early detection and early treatment.

What I'd like to dedicate most of this talk to is the issue of coercion as an element of mental health treatment. By coercion, I mean the use of violence, either actual or threatened, as a means of delivery of psychiatric services.

I'd like to give credit at this point to Professor David Cohen, formerly of the University of Montreal, who now teaches at the social work department at the College of Health and Urban Affairs at Florida International University in Miami. Dr. Cohen has agreed to assist in a challenge with respect to the overbreadth of the community treatment order provisions and the expanded criteria for involuntary commitment that came into effect in 2000 with Bill 68. The other name for that bill, in case you also hear reference to this name, is Brian's Law.

1630

We begin from the principle of individual autonomy: A person who is capable of making their own treatment decisions ought to have complete autonomy in respect of those decisions. If we are going to carve exceptions in respect of the principle of basic autonomy, it's going to have to be on the basis of well-thought-out and principled grounds.

In other areas of medicine, the examples that I can give would be the right to refuse blood transfusions, for example, on religious grounds, or the right to refuse cancer treatment which may or may not prolong one's life. We do not question the ability of people to make these decisions when they are dealing with their own lives. In the area of psychiatric care, however, in the name of society's obligation, as it were, to care for vulnerable and helpless citizens, which is sometimes called *parens patriae*, we have an exception.

If I were to suggest one huge source of stigma, it is the differentiation in our treatment of decision-making in the context of psychiatric care as opposed to any other kind of medical care. Such differentiation might be justifiable if the treatments that are involved were benign or objectively and universally beneficial to the people who were to receive them. But the treatments and the range of what is available to psychiatry in particular is anything but benign or universally beneficial.

I had an opportunity to look at a memorandum that was prepared—it's dated yesterday and provided by researchers—respecting the question of mental health law and involuntary hospitalization generally, and the ability, as someone had suggested, to sit on their right to refuse treatment, even to the point where they may turn

up dead. Firstly, such inflammatory language is extraordinarily—making decisions on such emotional grounds is something that we have to guard against. But I'd like to deal with the medications that are the traditional first line of treatment for schizophrenia and for any type of psychosis. These are medications called neuroleptics or antipsychotic medication.

In 1991, the Court of Appeal, in a case called *Fleming v. Reid*, described the side effects of these medications. It indicated that, "The use of neuroleptics in the treatment of various psychoses is generally effective in improving the mental condition of the patient by alleviating the symptoms of mental disorder. It is clear, however, that they may not be helpful in every case. Moreover, the efficacy of the drugs is complicated by a number of serious side effects which are associated with their use."

I'm just going to summarize some of the side effects that the Court of Appeal identified, and this was after extensive research was given to them. First is a condition called dystonia. This involves muscle spasms in the face and arms, irregular flexing, writhing or grimacing, and protrusion of the tongue. Another is acathisia, which involves restlessness, an inability to stay still. Then, Parkinsonisms: a mask-like facial expression, drooling, muscle stiffness, tremors, and shuffling gait. The whole panoply of side effects is described, all the way through to the occasional sudden death attributable to the antipsychotic medications. There's a description in the case of the condition of tardive dyskinesia, the uncontrolled flailing of limbs, as a result of long-term use of antipsychotic medication.

In the 1990s, the pharmaceutical industry developed what is a new generation of antipsychotic medications, and you may have heard of atypical antipsychotic medications. But I'm going to tell you a little bit about the research, and this is material that Professor Cohen has assisted me in putting together. It is essentially that any lessening of the side effects or improvement insofar as these different conditions that I described as associated with the traditional antipsychotics was simply a result of a reduction of doses. There was no increased efficacy or greater likelihood of success associated with the medications.

And this is what is most distressing: In the case of Zyprexa, a medication that as of 2006 was generating \$4 billion annually in sales for its manufacturer—and this is from a well-sourced article in the *New York Times* from 2006—there were extensive efforts to downplay the unique metabolic side effects that were resulting from administration of these medications, in particular the side effect of significant weight gain: in 30% of patients, more than 10 kilograms, or 22 pounds, and many patients in the first year of use had as much as 100 pounds of weight gain. The result—and this is what the manufacturer took great pains to downplay—was an explosion, amongst the population of people with schizophrenia, of diabetes, high-blood-sugar diabetes, something that, on a scale of debilitating illnesses, one would have to say is a very high-ranking concern. It reached the point where

there was litigation, of course, over these medications. I want to make a disclaimer here: I'm involved in none of that litigation.

The point that I'm making, though, is that we have to look at the different choices that we might propose to make for people who can't make their own decisions in a very different light than simply saying, "This person can't make their own decision, and therefore we should make the decision that they should take this medication." Because the side effects and the negative aspects of the medication—in some cases the intended effects of over-sedation—are simply too much for many reasonably-minded people to accept.

The Chair (Mr. Kevin Daniel Flynn): Mr. Swadron, you have a minute left.

Mr. Marshall Swadron: Well, I'd just like to talk about the impact, then, of coercion generally and how it works.

Many people are seen to take psychiatric medication voluntarily, and indeed many do. But when there is always the spectre either of detention or, in some cases, the use of direct violence, somebody being held down and injected with medication when they refuse to take it voluntarily and someone has made the decision for them to take it—this is a spectre that any person admitted to a psychiatric hospital, even voluntarily, will witness, not to themselves necessarily, but they will know that this is the end that will meet them if they do not take matters into their own hands and, in some cases, accept medications that they would rather not take—we have to be very careful and concerned about that.

I'd say that community treatment orders, in many respects, are just that: You do not get out of hospital unless you agree to take these medications. Resources are overwhelmingly allocated to people only if they're on community treatment orders.

People need three things, and I'll finish with this: People need a home, people need a job, and people need a friend. You can't tie these things to insistence that people take medications that aren't as effective in helping people with mental illness as any of these three things that I've just mentioned.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Marshall. We really appreciate the presentation. I suspect you've got some more to say. If there's a written submission you'd like to make to the committee, if there's anything you'd like to expand upon that you weren't able to today, please put it in writing and we'll make sure it gets out to every member.

Mr. Marshall Swadron: I'd be grateful. Thank you.

1640

BARRY HUDSON

The Chair (Mr. Kevin Daniel Flynn): Our next speaker this afternoon is Barry Hudson. Is Barry here?

Mr. Barry Hudson: Yes, I am. I've just made a PowerPoint presentation to follow what I'm going to discuss.

The Chair (Mr. Kevin Daniel Flynn): No problem. Like everybody else, you get 15 minutes. You can use that any way you see fit. If there's any time at the end, we'll see if we can split it amongst everyone who's here for any questions and answers.

Mr. Barry Hudson: Thank you very much. As introduced, my name is Barry Hudson. I'm talking on behalf of my son, pictured here, Barry Hudson II. I'm talking about autism. I've seen it in the periphery of the Hansard record, the transcripts for these hearings, but I've never seen anyone talk directly about it, so I figured it's my turn to talk. I want to talk about the reality of autism in Ontario that my son faces, as well as many other children, preschool-aged children, as a matter of fact. What I want to discuss is Autism Ontario, so we're on the same page educationally; the reality of wait times; the benchmarks that, as a completely biased individual, I will admit I see as administrative, not clinical; adult issues, the non-existent, the invisible; and concluding what I'm talking about.

The first issue: I'm sure you've heard about the DSM-IV as a diagnostic and statistical manual for diagnosing mental impairments, mental disabilities and mental diseases. It defines autism as a qualitative impairment of communication—a person may not be able to speak, may not be able to sign, may not be able to use pictures to display what they want to talk about, or get their needs met; qualitative impairments in social interaction—they can't join in social activities, there's no joint attention, eye contact, not part of the group, and isolation behaviour; and also restricted, repetitive stereotyped behaviours referred to as self-stimulatory. The stereotyped ones you hear about are hand-flapping, but they could be spinning wheels on a toy or spinning in circles in a room, and that can go on for hours.

From Autism Ontario: They say there are 70,000 people in Ontario with autism, children to adults, based on 2004 estimates.

The real issue is a growing prevalence and our lack of meeting that prevalence. The source for this information is the Centers for Disease Control in Atlanta, United States, and the UK health authority in England: In the 1960s it was one in 2,500; in the 1970s it was one in 450; in the 1980s it was one in 266; in the 1990s it was one in 200; in the 2000s it was one in 150, which is the typical number today. But UK health reports just recently—the CDC doesn't want to adopt the number yet, although they are looking at it quite closely in their own studies to be renewed this year—that one in 100 individuals will be born with an autistic disorder in the UK—confirmed, validated, and that's the number they use in their official literature today. I have a preference for the UK number because it's based on one national collection system, one national entity, one national body. It's probably more reliable than one in 150, because the one in 150 is based on survey and statistical results of six monitoring sites, as they call them, in the US. So that's an observed fact in the UK today: one in 100.

Why is it growing? There are many reasons. There have been many arguments about why: an expansion in

criteria, an expansion in diagnosis. That question is important to be answered, but if you're facing it—that's truly not a relevant question that I care about today for my son. I just know it is what it is, dealing with it daily.

The reality we have in Ontario, as I'm quite sure we're all aware—you've just got to pick up a newspaper now and again; and I just mean it's in the popular press, and I'm not surprised. The reality of wait times: According to the Queen's Park bureau reporter on August 18, 2009, we have 1,513 preschool children waiting for therapy.

The number may have come down a bit recently because the practice of the regions is to cull the herd, so to speak, in June. There has probably been some ebb and flow in that number, but it probably was not materially affected. If it has gone down 10% or 15%, I'd be surprised.

What is the reality? Children wait two to three years—plus to access clinical therapy. We know as a fact, through five decades of research, confirmed by 47 countries, 84 universities and 320 practitioners, that early intervention is critical. Not to point the finger at the government; it's just that the government's the current sitting person that has to deal with it. But even our sitting government agrees that early intervention is critical. I was on a television show last year, W5, and the minister, the Honourable Deborah Matthews, was on the same show, and she said exactly that, so we're not making things up.

What does it mean for a person with autism, a small child? In very simple terms—and I'll probably be vilified for simplifying it, but it's just to get the point across: If you're one year delayed in your skills and abilities at the age of two and you have to wait three years, assuming everything else is fine and dandy, by the time you get therapy, you're four years behind the curve. Our own personal wait time, in my family, was 34 months. Our funding starts October 1 of this year. It has taken 34 months to get there. That's a long time.

To impart our case again, just so you understand it, we've re-mortgaged our house. My wife quit her job to be our son's lead therapist and director of the program. We have depleted 100% of our savings and retirement funds. I even had the superintendent of financial institutions for Ontario unlock my locked-in pension funds so I could get the money to spend on my son's therapy. I do have to say that they turned it around quite quickly; I appreciate that. We lost almost everything. If our funding did not occur this October, our house would be going for sale. I actually signed the paperwork two weeks ago to sell our house.

I am not complaining about that—I want to be crystal clear. There's nothing I would not sacrifice for my son; absolutely nothing I would not give up for him. But what about the single parent making minimum wage? What can they sacrifice? What can their child face? What will their child see? What will happen to their child? These are rhetorical questions, obviously. But the reality is that the most unable to help their children are the ones who languish, and again, we—our society, collectively—are

doing this to preschool-aged children. That's the important thing to understand.

The reality of the wait times is poor fiscal management. We all have to take care of money competently, obviously. I did my own math. It is better than what U of T has come up with, but I'll take their numbers—you could throw a rock and hit the professor's window from here, I think. The University of Toronto in 2006 wrote a study in a department of health policy paper entitled the Cost-Effectiveness of Expanding Intensive Behaviour Intervention to All Autistic Children in Ontario—it's a long title.

At that time, the population they were looking at was 1,309. By expanding the therapy to all children for three years, the savings, based on ministry numbers—freedom-of-information act numbers; I didn't make up any of these figures—are \$45,133,011. That's assuming a 25% best outcome. What does "best outcome" mean? The research in the field calls "best outcome" a child who can integrate with his peers and not be noticeable as an afflicted individual. There is no cure, but I think the street term is "recovered." That individual can function, they can communicate as well as I can, they can hold a job, they can live independently. Twenty-five per cent is the figure they used, whereas the research supports 35% to 47%, so it's a very conservative estimate, and fair enough. That's what we should do: be conservative.

1650

I extrapolated that to the wait list today. It makes the savings over \$93 million, and these savings are solely on living supports. It doesn't bring into account any SSAH funding, any of the drug funding, any of the occupational supports funding. It's solely based on housing individuals with autism, based on the ministry numbers at that time. Indeed, the Canadian Senate, in 2000, confirmed the fiscal costs and the human costs.

The next issue I want to talk about is the benchmark criteria for how we continue help with our children. There are new benchmarks in a proposed state, and they've become the effective criteria today. When we went to our regional provider to sign our contract for funding yesterday, they gave us a copy of the criteria. It was the proposed benchmarks in a different font. I can quote them by word. I know them quite well. And even though they shouldn't be imposed, they are. Again, I have to live with it. I can't change it.

The only people I can find supporting these benchmarks are the panel itself and government employees. Not to be rude, but I spoke to 27 psychologists in four countries and I can't get any of them to agree to these being criteria to use in the treatment of individuals with autistic disorder.

What happens is, the required trajectory of that criteria only suits those that will be the best outcome, whether it be natural consequence, luck or whatever. It's a self-fulfilling prophecy: You delay therapy until the individual can't partake in therapy, and you say, "Oh, they can't partake in therapy. Cut them off." It's beyond deplorable.

Our son had challenges when we first started at home—nothing in terms of aggression, but he simply

would not comply; he would not attend. Compliance is not about stopping tantrums or making them quiet; it's about being able to partake in an educational activity to learn a skill. That's what compliance means in the world of autism. If our son had gone into the program under the current criteria, he would have been kicked out in six months, guaranteed. So we never would have seen what we've seen today.

Today, he's a verbal child. He had absolutely no words when he was diagnosed. He could not attend to any of his own needs. He couldn't express any of his desires. He couldn't indicate where he was hurt. And his self-stimulatory behaviour took over most of his day. It was a pretty rough time. If we had given up, we wouldn't see what we see today.

I have a little video of my son singing last night. It's one of his favourite songs.

Video presentation.

The Chair (Mr. Kevin Daniel Flynn): He's got a showbiz career ahead of him, I think.

Mr. Barry Hudson: The noise in the background, his brother, is just a typical two-year-old suffering from being a typical two-year-old.

The Chair (Mr. Kevin Daniel Flynn): Your time is up, but if you'd like to summarize, I'll give you a minute there.

Mr. Barry Hudson: I do appreciate that.

The summary, the bottom line that we're looking at, is that we're preventing the best outcome in what we do. It's poor fiscal management. If we look at the long term rather than the short term, we'll spend our money more effectively.

It's a human rights failure noted by the United Nations in 2006. The human rights committee of the United Nations, in commenting on Auton, said it's the most shocking thing they've seen, the BC lawsuit from parents against the BC government for autism therapy. They cut through the diplomatic language. They basically said, "Your charter means nothing now. If you don't enforce the fundamental rights, it's just a piece of paper," and I actually kind of agree with that. We must meet the standards of science today, and sufficient and appropriate funds are a requirement, not really a choice.

That's all I have today.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming, Barry. We really appreciate it, and thanks for the performance by your son there.

COALITION AGAINST PSYCHIATRIC ASSAULT

The Chair (Mr. Kevin Daniel Flynn): Our next presenter today is the Coalition Against Psychiatric Assault, Don Weitz, if you'd like to come forward. The presentation from Don is part of the members' package. You'll find it under your agenda. It begins with electroshock.

Don, like everybody else, you have 15 minutes. You can use that any way you see fit, and if you'd like to

leave some time at the end for questions, that would work out. If not, it's entirely up to you.

Mr. Don Weitz: Thank you very much. I thank the committee for allowing me to speak here today on an extremely serious issue which some of you may know about, namely electroshock, but the psychiatrists call it electroconvulsive therapy, or ECT for short. I hope by the end of my submission you will at least start to seriously question whether it's therapeutic as such and deserves the name "therapy."

I'm an anti-psychiatry activist. I've been critical for many, many years, over 30 years, of the system—in a constructive way, I'd like to say—here in Ontario and Canada.

Now, I'll get to the point very fast about electroshock. I just want to let you know that I think it's a serious mistake for you to get any kind of understanding of electroshock from watching the film *One Flew Over the Cuckoo's Nest*. Many people will probably have that shock scene fixed in their head. Basically, the only thing that is different from what you saw in *One Flew Over the Cuckoo's Nest* and the way they give it here in Ontario and other places is that the person doesn't shake as much. That's because the muscle relaxant is a muscle paralyzer, so that the diaphragm is totally paralyzed. I will get into the procedure, very much so, but my basic thesis, my basic point, I'll say flat out, is that we are here to urge this committee to recommend a total ban or at least a moratorium on electroshock in Ontario.

This is not the first time that many of us have spoken out to urge a ban. As you can read, CAPA is a group I've been associated with for about six years that does strategic political action around both electroshock and psychiatric drugs.

1700

Now let me go through, in the time I have, the procedure itself, which you'll probably not read about too much in the media or you probably won't even know about if you've seen a film. The first thing that happens is that the person—although I never had electroshock, a lot of my close friends have and I've read extensively in the literature—is given a tranquilizer the night before and not allowed to eat or drink anything for about eight to 10 hours. Then you're given a sedative and a tranquilizer so that you're asleep or unconscious during the treatment. Then you're given a muscle paralyzer which paralyzes all the muscles in the body so you can't move. It's called succinylcholine; that's the medical name. It's a derivative of the Indian root curare. Then the shock machine is turned on while you're lying, usually flat on your back. Oh, sorry: The electrodes are usually placed on one side or both sides. If they're on one side, it's called unilateral; if the electrodes are on both sides, it's called bilateral. They're usually placed over the temporal lobe, the seat of memory. That's why memory loss following shock always occurs and is devastating.

The current is probably twice the amount that comes out of your electrical outlet in this room. We're talking in the range of 200 volts, currently. It used to be lower, but

since the medication that's given to you before the current is turned on raises the seizure threshold of the brain, more electricity is required to produce the desired seizure, which is dishonestly, fraudulently called therapeutic. There's no seizure in medicine except in psychiatry that's called therapeutic. Only psychiatrists call it therapeutic. The neurologists do whatever they can to prevent you from having a seizure; not the psychiatrists. This is a deliberate induction of electricity to cause a seizure. It lasts about 60 seconds, then you go into a coma for 10 to 20 minutes, and you wake up in a recovery room, usually with a splitting headache that can last a day or longer; if you're lucky, it's a few hours. You may vomit, throw up a bit, be dizzy. You're confused, you may not know where you are—you're disoriented, is the medical term.

That, in short, is the ECT procedure, which is paid for by taxpayers' money in Ontario to the tune of \$1 million to \$2 million a year. That's a ballpark figure. I can't get accurate statistics on the OHIP amount of money, on the health tax dollars that are spent to produce a seizure in Ontario's citizens, but I have seen that it's at least \$1 million, and I would expect it's close to \$2 million.

The major effects of electroshock are memory loss and brain damage. The permanent memory loss can extend many, many years back—that's called retrograde amnesia; or it can extend forward—that is, after you've learned material, then you can't remember it. That's called anterograde. Retrograde amnesia is very common, so people sometimes are missing not just a few months but a few years of memories. I won't go into all of the details. There is survivor testimony in the paper that you have which I feel is just a very small sample of the growing and voluminous personal testimony of shock survivors in Canada and the United States. It's not pleasant to read, but it's honest and it's accurate. People generally don't lie about the effects of electroshock that they've had. Permanent memory loss, which the psychiatric profession had denied or minimized, including the Canadian Psychiatric Association, is extremely serious. How are you going to study or go to school and pass the exams when you can't remember the material—which Sue Clark, a survivor in Ottawa, has testified about? There's also the effect of psychological trauma. I've met a number of people who still show the effects of trauma.

You may wonder: Is this a minor treatment? Is this just a few people we're talking about, so we don't have to think about it? Well, I'd say one person to get shock is one too many. I have statistics from the Ministry of Health and Long-Term Care, as of 2004—and they're in your brief—that show we're talking about 1,400 or 1,500 people, sometimes every year, who get electroshock.

Most of the shock given nowadays is given as an outpatient procedure, I suspect, but I don't have accurate statistics because the Ministry of Health hasn't consolidated or doesn't have a competent method of collecting ECT statistics in Ontario.

By the way, no hospital is required to report ECT to the Ministry of Health. I got that from the horse's mouth,

so to speak. That's curious as well as disturbing, because when you give a medical treatment, you're supposed to report it, I thought, to OHIP. Of course, in order to get paid, you have to submit it, but when it comes to ECT, the doctors don't have to report complications; they don't have to report the number of ECT treatments or the major effects. I think that's scandalous, to say the least. It's also not very professional. How are you going to get a fix on a so-called treatment if you can't depend on hospitals to be honest? Listen, this comes from the Ministry of Health—and you can check it, and I hope you will: There is no regulation from the Ministry of Health that requires hospitals to report ECT. I'd love to see it.

By the way, the consent forms vary from hospital to hospital. Also, the ECT patient consent forms conspicuously avoid brain damage and memory loss, which has been documented for over 50 years. They're not just side effects; they're direct effects. This is knowledge that the psychiatric establishment has known, but they go to great pains to deny it or sanitize it in their position papers.

The best study of brain damage and memory loss, particularly affecting women and the elderly, as you can see in my paper, the main target groups—particularly elderly women over 60—is the Sackheim study, which I urge you to read. It's the best, and I'm not just saying it. Other people who study this say it is the best study, the largest study, we have to date on the effects of ECT. What did Dr. Sackheim, and four associates, find? He found massive, permanent memory loss, brain damage, particularly severe in women and the elderly. I'll repeat: particularly severe in women, including women with postpartum depression, but particularly elderly women.

1710

I myself have written a paper called Electroshocking Elderly People: Another Psychiatric Abuse. I am now calling it elder abuse. This is elder abuse sanctioned by psychiatry and the state, and that's not an exaggeration.

We have tried to interest the Ontario government several times, whether we're peacefully demonstrating at Queen's Park, as we did, some of you may know, on Mother's Day this year and Mother's Day two years ago. We did invite Health Minister Caplan, who replied by not replying, who replied by not bothering to even ask one of his bureaucrats or somebody in his department to show up to even find out what's going on and whether these people have something to say. That was a serious insult to citizens.

The Chair (Mr. Kevin Daniel Flynn): Don, you have about half a minute left.

Mr. Don Weitz: I will close by reiterating our basic request. This procedure, called electroshock, that always produces memory loss and brain damage has no legitimate therapeutic value. It must be banned. There have been other procedures in the history of medicine and psychiatry that have been banned with less evidence. It is time for the government of Ontario, and I hope this committee, to take seriously what I am saying, not just for myself but for many, many other people who have been victimized, traumatized and stigmatized totally unnecess-

arily by a procedure which is not scientific and which always causes harm. So I would hope, and I'm open to any questions—

The Chair (Mr. Kevin Daniel Flynn): Unfortunately we're out of time for questions, but you've been very clear in your presentation.

Mr. Don Weitz: Am I the last speaker?

The Chair (Mr. Kevin Daniel Flynn): No, you're not the last speaker. There are many others after you. I did want to thank you for coming today. We understood your presentation very clearly. I know the committee will take it into consideration.

Mr. Don Weitz: I should just add one quick thing; that this is—

The Chair (Mr. Kevin Daniel Flynn): I wish I could allow you to, but there are people who are waiting.

Mr. Don Weitz: It will take five seconds.

The Chair (Mr. Kevin Daniel Flynn): Okay, five seconds.

Mr. Don Weitz: This is a global human rights issue and it isn't restricted to Ontario or Canada. There are people as we speak, both professionals and survivors of electroshock, who are speaking out and want it banned. I wouldn't be surprised if there is a member's bill introduced in the Legislature soon calling for the ban of electroshock in Ontario. Thank you very much.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today, Don. It was appreciated.

PETER ANDRUSKI

The Chair (Mr. Kevin Daniel Flynn): Our next speaker today is Peter Andruski. Is Peter in the audience? If you'd like to come forward, there should be some clean glasses there and some water. You can sit at any one of the microphones where you're most comfortable. Like Don before you, you have 15 minutes. You can use that any way you like. If you'd like to leave some time at the end for questions, that's entirely up to you.

Mr. Peter Andruski: First of all, I'd like to thank you for the opportunity to speak to you today. I don't have any handouts for you, nothing for you to take away, other than what I'm going to tell you, and any questions you might have at the end I'll do my very best to answer as candidly as possible.

My name is Peter Andruski. I am the stepfather of a 25-year-old man who is recovering from the effects and the stigma of schizophrenia.

Over the last eight years, my wife and I have experienced the difficulties of obtaining help for our son, having had to resort to the justice system to access initial support. It's unfortunate that our health care system is structured in such a manner that an individual in need of help due to a medical condition must often reach a point where police involvement is required for them to receive the services and support they require.

Over the years we've struggled to access services for our son and ourselves, to help understand schizophrenia and cope with the changes that it has brought to our lives.

We've experienced a disjointed system, where there are pockets of good work being done, but unfortunately the lack of service integration limits its effectiveness.

Now that our son is doing well, I volunteer my time in support of individuals and families managing mental health concerns. I facilitate family education groups focused on recovery, participate as a regular speaker for family education groups and have delivered a number of public presentations encouraging people to see that mental health recovery is more than a possibility; it's a reality.

Over the last two years I've been a member of the core group of the Mississauga Halton LHIN detailed planning and action team for mental health and addictions, and their community engagement task team, as well as having been a member of the core group of their system integration group for mental health and addictions and the associated education and training task team. As a member of these teams, I've been able to provide the perspective of a family member as the LHIN's integrated service delivery model was developed and the process of implementation initiated. I've since resigned from my role with the LHIN to pursue focused educational opportunities directed at providing family members with the skills they need to help an individual manage a mental health concern, as well as the skills they need to sustain themselves while providing support to their loved one.

In speaking to you today, my perspective is solely that of a family member and a father. Please also understand that although I refer to mental health concerns, I am in no way intending to minimize the importance of addressing addiction issues as well. I consider them to be equally important, but my experience is with services providing support for mental health concerns rather than addictions. So today I'd like to offer you my thoughts on how I believe some areas of the system could be changed to improve the potential for positive outcomes of those individuals managing mental health concerns, and their families.

I had the privilege to attend Open Minds, Healthy Minds and have reviewed the Every Door Is the Right Door discussion paper. The desired outcome as set out in the paper of having an integrated mental health and addictions system, with the individual accessing services at the centre, directing their care and selecting their care options in the least intrusive setting possible, is the system that many of us wish for. From the perspective of a broad desired outcome, this is where I believe we should be setting our sights.

In the time that I have today, I would like to speak to you in particular about the involvement of the family and the supports that the family might need to be a positive influence in an individual's recovery. When I speak of "family," I use the term broadly to include any person that an individual considers as family rather than a purely biological classification.

My perspective comes from my experience as a father who has been challenged by the system to help his son recover from a significant mental health concern, while at

the same time struggling to find supports for myself and my wife to help hold our family and our relationship together and resist the silent push of our mental health concerns as they attempt to consume every aspect of our lives and our identities.

My experience has been that family and family involvement is viewed in many different perspectives on the path of mental health recovery. At times we are seen as unwilling to co-operate with a system that we feel doesn't do enough to solve the problems that mental health concerns have brought into our world. We're often seen as a nuisance, interfering in the attempt of service providers to provide care that they believe an individual should receive. We are often viewed by our loved ones, the ones we are trying to support, as unsupportive, interfering and manipulators of the system to achieve our goals rather than theirs.

On the other side, there are times as well when we are viewed as important if not integral: an integral component of our loved one's recovery. We're viewed as the primary support system for our loved one as they travel on their path of recovery. It is this perspective that I would like to see as the norm rather than the exception.

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Respecting those cases where individuals do not want their families to be involved, I'd like to offer you my perspective on what needs to be done so that families that want to be supportive acquire the appropriate skills and resources to be effective contributors in our loved ones' recovery.

In order to be effective in supporting a loved one, one of the most difficult challenges for family members is to accept that a mental health concern has become part of our life and that it is not something that is going to be addressed with the expediency of mending a broken limb. We also have to accept that the system is not going to house our loved one until the problem has been corrected.

It is at this critical time that family members need to be supported in order to persevere through the initial period of disbelief, grief and the sense of lost expectation that is often experienced when we learn a loved one has a mental health concern to manage. My opinion is that it is at this critical time that family members need to be presented with reinforcement that mental health concerns can be dealt with effectively and that people with mental health concerns can lead independent lives that are fulfilling to them. It is also at this time that family members need to begin the process of becoming educated about the mental health concern their loved one is trying to manage. In my opinion, it's imperative that during this period, family members need to be provided with supports to begin developing their own coping mechanisms to enable them to manage the emotions and pressures that being the source of primary support requires.

In my experience, I have found that it is during this critical time that support for family members is often lacking. At the time when we need it the most, it's often least available. There is advice available to guide us on

what we should do to provide effective support for our family member, such advice as, "Provide a supportive, stable, calm environment." Service providers are equipped to provide us with specific guidance in supporting our loved one.

Unfortunately, that's not always the case when it comes to providing support for us. To support ourselves, we're offered suggestions such as, "You might want to find a support group," which at that particular phase is not particularly helpful. There appears almost to be an underlying attitude that if our family member is able to manage their mental health concern, any issue that we might have will naturally work itself out.

I would caution against taking this perspective and overlooking the need of family members for appropriate support of their own. Doing so will only serve to substitute one person managing a mental health concern with another. If we are not provided with adequate supports for ourselves in supporting our loved one, there is a risk that we will only take their place or join them in the system.

So my suggestion is: Rather than focusing solely on the role of the family in an individual's recovery and leaving support of the family to those service providers that choose to offer it as part of their service, I would like to suggest that structured family support be incorporated into the recovery plan of the individual from the beginning, and that it become a formalized part of working with someone who has a mental health concern. Supports for the family, as for the individual, are expected to change in focus as the individual and the family progress on the path of recovery. With that in mind, supports for the family as well as for the individual need to be available across the continuum of care and varied according to the needs of the family across that continuum.

I think it's important to take a minute to speak briefly of those cases where an individual does not want to have their family involved in their recovery plan. The reality is, that is the case sometimes, and individuals don't want their family involved, for whatever the reason might be.

If this is the case, one should not assume that the family is not in need of support. We are fortunate, my wife and I, that our son has wanted us to be involved in his recovery. Having spoken to many family members where this is not the case, where their loved one does not want them involved in their recovery, their need for support is still substantial. Not only do they want to understand the mental health concern in an effort to understand the behaviour of their loved one; they also have to cope with the realization that they may have little, if any, opportunity to be involved. In cases such as these, please consider that these individuals may be in need of significant support as well, and they should not be excluded from services because their family member has not included them in their recovery team.

As the system changes, my belief is that if provided with appropriate and ongoing supports, of which education is a key component, families can be a significant asset to the recovery of individuals managing mental

health concerns. In supporting families to support our loved one and sustain ourselves, system capacity can be increased by increasing positive recovery outcomes, subsequently increasing individual and family independence, and ultimately resulting in a reduction of individual and family reliance on specialized mental health services.

To this point I've talked about what the system needs to do, what we'd like to see changed in the system and how the system needs to support us, but it won't work if we don't do what we need to do as family members. We need to understand as family members that we have a role to play. It's not all about doing for us; we have to do as well. In order to achieve the best outcomes possible, we need to accept the responsibility of a partner to the system, the service providers and our loved one. It's through a working partnership and an attitude of collaboration, trust and mutual respect between family members, service providers and our loved ones that we will achieve the best outcomes possible.

I believe that as work continues to educate youth and the public in general about mental health concerns, the stigma attached to mental health will begin to subside. My hope is that it will become easier for people to see mental health concerns as manageable and those managing them as contributing members of their community.

To you, the committee, I would commend you on your vision and for taking this step forward to bring change to the way that mental health services are delivered and mental health concerns are viewed. I suspect that as you attempt to move the vision into practice, you will encounter challenges at many levels. You may need to accept that in order to effect significant change to the system, there will be difficult and in some cases unpopular decisions to be made. Resistance to change should not be unexpected, and agreement from all sides may not always be achievable. What I would like to ask of you is that you accept the challenge to lead us to our goal. To only provide guidance and encouragement will not be enough. Without strong leadership, I'm afraid we will be left with an opportunity to change the system that fades to the background because the will has not been there to make it a reality. We need your help, and I hope that you're up to the task.

Thank you for your time.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Peter. You've got about 30 seconds left, so I think probably the best thing for me to do is to thank you for coming today. Thank you for telling your story to the committee.

VINCENT DE MERCEDES-ANGELSSSEN

The Chair (Mr. Kevin Daniel Flynn): If we could move on, then, our next speaker now is Vincent de Mercedes-Angelssen. Please come forward, Vincent. Make yourself comfortable. I think you've been here since the start. Like everybody else, you get 15 minutes. You can use that any way you see fit, and then at the end,

if there's any time for questions, we'll split it up amongst everybody.

Mr. Vincent de Mercedes-Angelssen: Thanks. I'm afraid the previous speaker ruined my presentation. I intended to be dramatic, but he said it so well.

I have to warn you, I'm feeling very emotional and I might cry. If that happens, I hope that you stop your timers so I have my 15 minutes.

The Chair (Mr. Kevin Daniel Flynn): Do you want to grab some water before you start?

Mr. Vincent de Mercedes-Angelssen: Certainly.

The Chair (Mr. Kevin Daniel Flynn): We're all yours.

Mr. Vincent de Mercedes-Angelssen: All right. As you know, my name is Vincent de Mercedes-Angelssen. I have no professional credentials in the field of mental health and little formal education. I am simply what has come to be known in the mental health system as a family member and a primary caregiver.

1730

But I am also a man of many hats. I have learned, in some 30-odd years of caring for my loved one, to serve as a cook, a barber, an errand boy, a nurse, an impromptu social worker and a spur-of-the-moment advocate. I have learned when to rage and when to pray; when to curse and when to hold my tongue. I have learned how to ask—no, to beg—for help, for understanding, for support.

I am by nature a caring, even solicitous, human being, but I can be at times the monster, the hypocrite, the scheming two-faced stranger who wants to harm and plot against the one I love and care for. I am the one who runs for help and the one who runs for cover; the one whose presence is abhorrent yet needed and expected; the one who loves and cares too much and yet not enough. I am, in short, my brother's keeper.

I want, first and foremost, to thank you all for allowing me and other family members to voice our hopes and our concerns in order to help, if ever so modestly, in the commendable task at hand: the transformation and optimization of our mental health system. This is, needless to say, a truly ambitious project, and we praise and applaud the will and the efforts from all of you in the government, the various agencies and organizations, and all the other people that have come together in this endeavour.

I will not attempt to dwell on what has already been presented, discussed and proposed by others far better endowed with knowledge and talent, but perhaps I can offer a handful of ideas and experiences that might prove of some value along the way.

Our concern, as primary caregivers, is that, as the provincial health system is shifting from a focus on acute care to the education, prevention and management of chronic diseases, an important group of people in need of immediate medical help—in particular, the so-called chronically ill—will be bypassed in order to concentrate valuable, always scarce resources on models that will not, frankly, help or even alleviate our seriously compromised situation and would not, in our opinion,

based on our long and arduous dealing with the system, provide us with the professional services and care that our family members so desperately need.

Another thing that worries us is the apparent eagerness—well-intentioned as it may be—to shift the rendering of services from hospitals to community care facilities. There is merit to that idea, but the truth is that at present, the transition from institutional to community care is in many cases non-existent, and when it does exist, it is jagged, ineffective and, sadly, in a considerable amount of cases, downright detrimental, particularly when, more often than not, decisions to discharge patients into the community are made in haste, pressed as the hospitals are for the need for beds. This is not to say that we should reject this concept. I am sure that it has worked well in many cases, but we should try first to put in place a safer, more efficient program to coordinate transition and to ensure proper continuation of care and service.

On the issue of emergency services, much has been said and studied regarding this essential, invaluable service, so we all know by now how strained their resources are and how understaffed they are. But the sad reality is that making use of emergency services at any hospital in Ontario today can be just as traumatic as the condition that brought you there. For a mentally ill person, the experience is even worse. Emergency services for psychiatric patients can only be classified, without fear of exaggeration, as miserable, and this is not to reflect on the quality and general disposition of the good doctors and the rest of the professionals who happen to work in those facilities.

Let me just say that if you are in need of fast medical attention, do not try the psychotic, disturbed approach. It doesn't work. You will still be told to take a seat and wait your turn. It is no wonder that many, as my own family member has done, bolt for the door and leave in disgust. I cannot help but wonder: If a person arrives, by whatever means, at emergency presenting symptoms of a mental illness, if their case is even reinforced by the input and testimony of people that go along with that person, why is he needlessly detained and delayed at triage?

If the facilities are there in the form of a psychiatric ward, why not streamline those patients to where they can get, if not immediate attention, at least some reassurance that they are going to be looked after?

The emergency rooms, as everybody knows, are populated by all sorts of people with all sorts of conditions: heart attacks, broken bones, burns. Their symptoms and their conditions are more readily perceived. A mentally ill person, even when a full-blown storm is raging in his mind, is less able to convey the immediate need for attention, but that person may have not been able to eat, rest or sleep for days. The voices in his head are threatening him, taunting him relentlessly.

His need for assistance is just as urgent, yet even after a mentally afflicted person manages to get through the triage ordeal and he is finally sent to the psychiatric ward, he will have to wait on a chair, a cot or a stretcher

for hours on end—more often than not, overnight—until a psychiatrist, an intern or a case worker comes to see him. If he is lucky enough, he will be assigned a cubicle where he can rest while waiting with a bit more privacy. But do not count on it, because he might be asked, many times, to go back to the chair outside, since that cubicle is needed to interview other patients.

Even when a Canadian emergency department triage and acuity scale has been put in place to minimize subjective determinations of urgency, and even after revisions have been made to further define the urgency of people with a mental health complaint at emergency departments, service is still more readily available for non-psychiatric cases.

Chronic psychiatric cases fare even worse. In a report in the *International Journal of Mental Health Systems* dated June 30, 2008, under the heading “A Qualitative Study of a Psychiatric Emergency,” it is stated that “people who had used psychiatric emergency services at least 11 times over the eight-year study period had lower rankings of urgency.” In my particular case, I would say I have used emergency, since 2005, five times already.

In a series of articles in the *Globe and Mail* of November 2008, even psychiatric professionals concur in that psychiatry is “a specialty relegated to basement” and that psychiatric wards tend to be hidden away in physically unpleasant places, and inadequately furnished, because mental health has always been “the last to be funded and the first to be cut.” No wonder mental health is called the pariah of the health system.

But it doesn't have to be this way; it must not be this way. We need to find ways to attend to those who are ill—now. Rather than the promise of prevention, we need assurances that strategies will be developed and methods found to provide efficient, expedient and consistent services now.

The need for this is great and is pressing for those who are affected by a chronic mental illness, particularly for those that are non-compliant: those who refuse to accept that they are ill and who are consequently far more difficult to treat. “Well, your brother is the one who refuses to be helped,” I have been told, not once but several times by many professionals to whom I went for help.

So what are we to do when it is in the very nature of the illness to suspect, to deny, to refuse service? Should we surrender? Abandon our loved ones to chaos and doom because they cannot objectively make what would be, in many cases, a life-saving choice? We need to revise rules that at present are confusing and draconian and only serve to scare mental health professionals and make them shy away from applying measures that could expedite the provision of service.

As the privacy act now stands, we are in limbo, or perhaps I should say hell, unable to get help, so that our loved ones deteriorate until the only recourse left to us is police intervention and emergency.

1740

The Standing Committee on Social Policy—

The Chair (Mr. Kevin Daniel Flynn): If I could just jump in, Vincent, you've got about three or four minutes left and you may not get through everything. So if you want to focus on the things you really want to get across to the committee—I just don't want to cut you off at a point where you've still got something left to say.

Mr. Vincent De Mercedes-Angelssen: Okay. I have to say that the system as it is now is not really helping because even though there are many agencies in place, most of them don't have the necessary things in place to help us. First of all, there seems to be a 9-to-5 approach to services. As you know, mental illness is not a 9-to-5 occurrence, and if you need help, you end up going to emergency.

On one occasion, my brother begged me to call emergency because he couldn't rest; he couldn't sleep. I phoned up and the person at the other end asked me to describe the symptoms, what was going on in our home. I said, “My brother cannot sleep,” and he said to me, “Well, this is not a hotel. You can't come here to rest.”

When we went for a referral that we needed desperately, his family doctor, even though he was on the verge of retirement, could not provide it. He did not know who to refer this person to.

When we looked at the website for the College of Physicians and Surgeons, we got a list of 30 physicians. We called; we only got seven replies. None of them would take him, either because they could not take more patients at the moment or they provided services in other languages or they said, “Go to a hospital. That's your best bet.”

So obviously there are no resources there. What we need is a central depot, if you will, that will be there 24 hours for us, the family members, and the patients, the clients, the people who are in desperate need of help.

Also, the facilities are terrible. When we go with our loved ones to an emergency service, not only are they made to wait overnight but when they are looked after, they have to sit on a cot or a chair for hours on end overnight. When they are put in a cubicle, they have to go outside because they have to use that cubicle for somebody else, to interview somebody else. So obviously hospitals need to expand the services for mentally ill patients.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much, Vincent. You got your point across very clearly. Thank you for coming out today on behalf of your brother, as well.

Mr. Vincent De Mercedes-Angelssen: I thank you.

HEATHER DRUMMOND

The Chair (Mr. Kevin Daniel Flynn): Our next speaker this afternoon, after Vincent, is Heather Drummond. Heather, if you'd like to come forward, make yourself comfortable. Like everybody else, we've got 15 minutes allocated. You can use that any way you see fit. If you don't use all the time, we'll split the time at the end for any questions.

Ms. Heather Drummond: Excellent. Mr. Chair and members of the panel, I'd like to thank you very much for giving me the opportunity to speak today. I am primarily here as a concerned member of the community, but what is informing what I have to say today is that I have been working in the mental health field for over 15 years. I am currently a full-time college counsellor in one of the 24 colleges in Ontario. I am a very active executive member of the Ontario College Counsellors' association. I'm also a very active member in the Ontario Coalition of Mental Health Professionals.

Also, I'd like to say that my colleagues thought I should mention this: Today is actually my 40th birthday. They thought this would be an excellent time for me to speak on a panel like this because I have wisdom now, so I have things to share.

I'll give you a little bit of background about OCC so you know where I'm coming from—Ontario College Counsellors. We're in our 42nd year of really advocating for quality, accessible, affordable mental health services in the college system here in Ontario. OCC has over 160 members well qualified to offer various forms of psychotherapy. We practise under the title of college counsellor or counsellor. OCC tirelessly promotes policies and practices that surround our ethical responsibilities to students suffering from mental health issues. We have very stringent standards of practice. We're dealing with students roughly from 17 to 65-plus; it's quite an age range. We're seeing mental health issues across the lifespan, similar to what the communities are seeing as well.

OCC absolutely does support the objectives of the Regulated Health Professions Act, and we're very confident that when the College of Psychotherapists is fully in place, our members are well educated and well equipped to qualify under the auspices of the Psychotherapy Act.

So this is a great opportunity that my colleagues have volunteered me for, to be able to let people know more about college counselling, because there is that notion that college counselling is bad hair days and breakups. I'm not going to lie to you; there are occasionally those issues because of the nature of the population and the age. But we are seeing mental health rapidly increasing in severity, and at the same time a lot of the mental health services are rapidly decreasing. I can echo what has been said previously to me by the very moving talks by other people: It's the first thing to go; it's the first thing to get cut in a college. That's essentially why it was really important, even though I'm terrified today to speak in front of you, for me to have the voice of college counsellors and what we do in the college system.

We're pleased that you're taking this opportunity to hear real stories from the community, real stories from the mental health providers, because there is a wealth of professionals available in the communities now that are equipped to offer the services. It's just the money and how to place it and what kinds of services to offer, because there's always, obviously, like with every profession, a power struggle amongst who is the better

professional to offer programs, to be the ones to empirically deal with certain mental health issues.

But we are increasingly seeing very, very complicated mental health issues at the same time as our college counsellor complement has, year after year—I've been at this college for six years and since I've been there, we've lost three full-time counsellors, yet we've increased by 6% this year. We have five people at four campuses that see over 3,000 students a year. It's a free service. It's great, but it's dwindling rapidly.

Just to give you an idea, we're dealing with students who are actively suicidal, who are dealing with multiple levels of eating disorders, people who are engaging in self-injurious behaviour at varying levels, depression, anxiety, chronic illness, physical illness, people who are dealing with deaths in their family, physical and sexual assault, post-traumatic stress disorder. Also, just because of the span that we're dealing with, we're dealing with a lot of people for whom it's their first time away from home. It's very stressful to leave home, make new friends and all of a sudden have to do your own laundry. Just having that, alone, is very stressful, and also bringing on different mental health difficulties for them.

Also, it seems that in the community it's very easy for me to find mental health support for somebody who is incredibly severe. I can easily call up a psychiatrist, get a referral, get them into the hospital, but they have to be so severe. We deal constantly with high levels of suicidal ideation or high levels of threats to kill themselves, and very often I've sat in emergency rooms with students and they're in and out within an hour. The thing is, they're not well enough to be in and out within the hour. If they're not severe enough to be in that type of setting, there need to be settings within a continuum where they can be safe, where they can get the treatment they deserve.

Also, if they're not on the severe end, sometimes it's underappreciated just how being burnt out—handling school is very difficult. The reality of people in the post-secondary world, whether it be college or university, is that they have to maintain a job. Many of them maintain a job, a family—the sandwich generation, taking care of sick parents and taking care of their own children, all while attending a full-time course load. I came through the college and university system and am currently a doctoral student at the University of Toronto, and I'll tell you, the college system just packs these students full of courses. Where in university I'd have a nice five-course load, they can have six, seven or eight courses in a semester, so it's underappreciated, the level of stress that these students are under.

1750

For me to find somebody in the community, once they've transitioned from the college, who's affordable and accessible is near impossible. The only other agency—I work in Hamilton—that I can refer to for kind of a moderate level would be Catholic Family Services, a fantastic agency. However, they're limited in funding as well. So these students end up lost in the system, because

to pay for a private therapist is prohibitive for somebody who's just had several years of Ontario student loans, several years of trying to support a family, several years out of the workforce. So it's near impossible to get adequate mental health care for them.

Also, it would be very helpful to be able to have community agencies or college or university agencies—call it counselling departments—working in tandem, some sort of program funding where they can work together because, when students are transitioning out of the college or they need a little bit more support than we're able to offer in our particular college setting—to be able to work together for an easy transition to the appropriate mental health that they need.

Improving our society's mental health access is more than just throwing money at the existing programs. There are great programs; don't get me wrong. But on average, to get a student who's not incredibly severe—maybe they're moderately severe—into, say, a DBT program, dialectical behaviour therapy program, takes six months to a year. They may have dropped out of school by that point. They may not have been successful. They may have been asked to leave the college until they have sorted out their own issues. Once they're not a student anymore, the college counsellors no longer can see them for mental health support.

One thing the colleges and universities offer is just-in-time service, because we're dealing with the population a lot of time as it's happening on campus, in classes. They can come between classes. There tends to be less of a stigma when it's on campus. They'll access it quite quickly. When we do refer out, we tend to lose students. They tend to be more comfortable coming within the actual institution rather than leaving for counselling outside.

Within our population, especially on the younger end, there is a lot of early-onset schizophrenia, different kinds of psychosis. It's the age in the developmental age range, so college counsellors are often seeing the first mental health issue that that student has ever experienced. They often present—because I think it's one of the top five stressors, to go to school and maintain family life. Then add your car breaking down, and then you have a death in your family, very stressful events, so a lot of mental issues surface at the time of the college experience.

The reality is that, yes, there is private counselling available in the community, but we're looking at anywhere from \$120—you might get it for \$80 an hour—to \$350 an hour. It's not even in the realm of what a student can afford to pay for. Very often we're giving out food vouchers for \$25 just because they can't eat. They're not going to be spending it on their mental health.

There are community agencies available, as I mentioned, like Catholic Family Services. However, because of their limited funding, six to eight sessions is what they have available at the most. There are OHIP-funded agencies where they're very good at doing the assessment, but there's not enough funding or time to do the actual treatment, which is what the students need.

Like I said, wait times can be just astronomical, which then upsets their flow of being able to finish their college program on a timely basis so they can get out and feel like they're a productive, contributing citizen and be independent and support themselves.

The wait times in the colleges right now are getting longer and longer because the counselling complement keeps shrinking and shrinking, primarily because we don't have what's called targeted funding in the college system. Our disability services cohorts have targeted funding, meaning that the ministry provides money to the colleges to pay for the disability services that they offer. There isn't targeted funding for counselling departments, so what ends up happening is that when the college has to make budget cuts and has to balance the books—we cost the college money, we don't make money for the college, so we tend to be cut first. That's the reality.

My suggestions would be to increase accessible community mental health programs with both a medical model focus—I don't come from the medical model philosophy, but I'm not discounting what the medical model has to offer. However, that is all that seems to be available in the affordable realm for the particular population I work with. What I'm suggesting is, in tandem, we also have more psychosocial-based programs that are accessible and affordable for people in the community. Create community mental health programs that allow for community and different collaborations so that we're able to work together—flow of services and so forth.

I'm from Alberta originally, and I'm saying good things about Ontario. I think Ontario has been doing a great job with battling the stigma around mental health. I think that we need to continue with the campaign about just getting rid of the idea that people with mental illness have no worth or that they should be relegated to the basements of a hospital.

There's a program that British Columbia is piloting through the Canadian Mental Health Association: the Bounce Back program. It's a start. What I like about that program is, it's putting the locus of control into the client's hands. The client is learning how to improve their mental health. They're learning different strategies to help themselves, rather than relying on a physician, a psychiatrist or different antidepressant medications. It's a program that's teaching people skill sets.

There's an assumption in our society that everybody comes from a fabulous family and everyone has the same skill set, and it's not the truth.

The Chair (Mr. Kevin Daniel Flynn): You have about 30 seconds, Heather.

Ms. Heather Drummond: I can go really quick.

I think we need to decrease the hoops that clients have to jump through. For me just to get a student on a wait-list at a mental health program, I have to convince a physician that they should send a referral to that particular program. That's not always that easy because of physicians versus counsellors. So, lessen the hoops so that there's no reason why anybody from the college of psychologists, the college of psychotherapists, or social

workers, is not equipped to be able to refer to those particular agencies directly.

The Chair (Mr. Kevin Daniel Flynn): Thank you. You did a wonderful job. Tell your colleagues the committee said you didn't look a day over 30.

Ms. Heather Drummond: Thank you. I'll come back tomorrow. No, I won't.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming, and thanks for speaking out on behalf of the colleges.

Ms. Heather Drummond: Thank you so much for your time. This is a well-worthwhile effort.

VICTORIA LONG

The Chair (Mr. Kevin Daniel Flynn): Our last speaker of the afternoon is Victoria Long. Victoria, if you'd like to come forward. Make yourself comfortable. There should be some clean glasses there and some water if you need any. Like everybody else before you, you get 15 minutes. You can use that any way you see fit. If you'd like to save some time at the end for any questions, that's entirely up to you.

Ms. Victoria Long: Hi, everyone. My name is Victoria Long. I'm a recent graduate from the University of Toronto and a volunteer with the Schizophrenia Society of Ontario. I just want to thank you for the opportunity to speak with you today, and in particular, thank you, Mrs. Elliott, for introducing the private member's resolution that led to the formation of this committee. I can imagine that absorbing so many presentations is not the easiest of tasks, and I think that a review of Ontario's mental health and addictions services cannot be a light undertaking, but then again, mental health issues are not easy. They are complex, difficult, emotional and deeply personal.

This story is not entirely mine to tell. I cannot speak on behalf of my mother, who vivaciously and courageously fought her mental illness throughout several turbulent years. Even as a close family member, I cannot fathom how turbulent it must have been for her. So to speak on her behalf would be, in many ways, disrespectful. But I can speak as an Ontario citizen concerned with the well-being of other families who are dealing with the onslaught of mental illness, and I will speak as a daughter who suddenly became an unequipped caregiver and, as a result, struggled for several years as a young adult attempting to help make sense of what was happening to a loved one and often bearing the guilt of not having done enough.

1800

In 2001 I was 17. Midway through my last year of high school my mother never came home one day. After being held in suspense as to her whereabouts, my father and I received a call from a Toronto detention centre and learned that my mother was being detained as the result of a non-violent criminal charge. I learned that a mental illness had started to take over and that strangers had been affected by her inability to consistently distinguish

between reality and delusions. There had been no previous correspondence from any justice or law enforcement agent to our family, nor had there been any notice from the family doctor flagging any symptoms. My mother was and is a capable person, and, as a nurse clinician described, at the time she was competent in all spheres of functioning. So I did not know that there had been a severe problem developing, and I did not know enough about the signs and symptoms of mental illness.

Despite an outpatient court support program, my mother's health unravelled quickly, and it came to the point where she was not able to take basic care of herself and was not able to relate coherently with others. She needed constant support.

The period between 2001 and 2005 saw a long stream of discussions, meetings and calls taken by myself or my father and my mother with legal counsel, probation officers, police officers, social workers, nurse clinicians, psychiatrists and general practitioners. Despite the involvement of so many, there never seemed to be any comprehensive and coordinated health, housing and support program. There was no plan. Aside from the lack of affordable and suitable housing, I was generally not concerned about the lack of services but rather about the disarray of countless different services and an absence of communication between them.

During this time, my mother was asked to attend many court hearings, was evicted from her apartment, was held overnight at our local police station because they were concerned for her safety and was escorted to hospitals by means of the forms that my father and I filed with a justice of the peace.

I think my key message here is that the justice system is not the appropriate framework in which to process mental health issues. The justice system cannot continue to be a revolving door into temporary services that only exacerbate the illness and treat individuals as offenders as opposed to patients. It was a devastating shock to first learn about a loved one's severe illness by way of the justice process, and it was confusingly painful to navigate a criminal justice system on top of managing the illness.

I find it deeply disturbing and rather outrageous that during the early stage of my mother's illness, we came across a comment from an involved professional that a jail sanction seemed to be a useful deterrent to her behaviour. At a later stage, I vividly remember a justice of the peace telling me that he does not like having to sign the forms under the Mental Health Act granting the police the right to escort an individual to a hospital because the repercussions of such legalities tend to tear families apart. I told him I wouldn't let our family be torn apart by this.

But that was a very heavy promise to keep, and that brings me to the issue of family support. I began by stating that I would speak as a daughter and a caregiver, and I want to underline that while mental illness primarily affects one individual, there is a damaging cascading effect on family members and caregivers.

After graduating from high school, I entered U of T, but over the course of my first few years, I was definitely

overwhelmed by my family's situation. I ended up losing my scholarship because I had difficulty maintaining the grades I was capable of, and as a consequence, my student debt grew. I withdrew from school and worked full-time for close to two years, but the situation took a heavy psychological and emotional toll. I spent much energy seeking out resources for my own stability. I had many appointments with psychotherapists, psychiatrists, counsellors and the university's AccessAbility services. I eventually did return to school, and I completed majors in peace and conflict studies and criminology, determined to gain a better understanding of systems that really do affect families.

It's now 2009, and it's only in the last couple of years that I can say that my family has settled from the reeling effects of mental illness. My mother is doing well. Upon her recovery, she volunteered with the CNIB. She learned Braille and transcribed books. She has reconnected with family members and is able to take care of herself, thanks in large part to her Ontario disability support program payments, which she relies on.

I am volunteering with the Schizophrenia Society of Ontario and I will be facilitating their Strengthening Families Together program. I am glad to speak publicly to you of my experience.

Looking back, it's difficult to prioritize what needs to be done, but as with most challenges, I think the best preparation is knowledge. I ask that education be brought into schools so that youth, guidance counsellors, teachers and administrative staff are aware of symptoms and know where to guide people towards the proper care.

I also think that those developing mental health policy might benefit from practical exposure to the issues they are addressing. As I highlighted, mental illness is deeply personal and I think it might be very beneficial for public servants to visit hospitals and to have face-to-face discussions with front-line caregivers.

My thoughts also veer towards educating family doctors about serious mental health illness so that if they are not equipped to handle those illnesses, they are able to recognize the signs, make timely referrals to specialists and inform and work with families.

Secondly, I recommend that the committee study the entry points into the mental health services framework. I believe there's an unnecessarily large number of people slipping in and out of the justice system who would gain a lot more from appropriate health services and benefit from support of longer-term social programming.

The lack of communication and coordination between various social services becomes really acute if we think about how many hours of court time are elapsing, how many legal aid dollars are being spent, how many valuations and repetitive consultations are occurring, and how many frustrating efforts are burdening families.

We don't tend to ask those with broken legs to run marathons, or those with heart failure to lift tonnes, but I feel we often ask so much of individuals with mental illness and their caregivers. Why?

We can't always control what happens to our health or the health of loved ones, but I think we do have a choice

in how we react, and we all have a role to play. We owe it to people who need help, to respond with compassion, respect and diligence.

Thank you for listening, and I'd welcome any questions.

In my handout, I have a chart at the back just to give an overview of the number of services we dealt with, and how many people were involved and had to be managed by a single family.

I'd be happy to take any questions or discuss anything further.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Victoria. You probably left time for maybe one question from each, starting on this side. Anybody? Helena?

Ms. Helena Jacek: Thank you very much. That was an excellent presentation. You've certainly reinforced a number of things that we've heard. But I wanted to talk a little bit about the balance of the individual in terms of their rights to privacy, to refuse treatment. We heard a lot about that earlier today. You actually had to use a form 2 process. How do you see that balance?

Ms. Victoria Long: I think that was a very difficult thing to manage, to have to sign the form 2 and then know that my mother's privacy and individuality was at stake.

I think what might be helpful to look at is to notice that sometimes the individual is not able to manage these issues during crisis time. So in order to perhaps respect the person's privacy and abilities, it might be useful to not have to demand so much at a crisis period, whether that be demands coming from the justice systems, from forms having to be signed. If there's a lag time so that the person can at least recuperate and exit the crisis stage of an illness, that might be a helpful thing. At that point, families could discuss and interact with the professionals. And when that person emerges—because there are cycles of crisis—from that crisis, perhaps at that point they might be able to sign forms and answer questions.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Victoria. Sylvia or Christine?

Ms. Sylvia Jones: I really want to thank you for your being the last presenter, actually, because you've done a very nice job of bringing in the role of family. What we've heard a couple of times—and I'm pleased to see you've highlighted it as your third point—is that we have to stop dealing with mental health illnesses as a criminal issue. I don't know if we have enough time, but any suggestions that you would have to bring it back into the health realm.

Ms. Victoria Long: I think you could start at the very beginning. If a police officer or any law enforcement agent notices that an individual is behaving erratically and is detained, I wonder if at that point, before any detention or any legal sanction is imposed, families and family doctors could be consulted first. Because I think that's exactly the entry point at which it happens, at the very beginning, and then it just cycles through the justice system.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Victoria. France, you've got the last question.

M^{me} France Gélinas: You mentioned that when you were in front of the justice of the peace for a form 2, he or she told you that they didn't want to sign this; it breaks family. Looking back, would there have been another way to get your mother the treatment she needed?

Ms. Victoria Long: I think it would have been much more comfortable if this was something—I understand the legalities that need to be addressed, but if this was in a family health setting, it would have been a lot more comfortable. I'm not too sure how else to answer that, but it was just very difficult to have to swear under oath and have the legal formalities, assigning that to families. Perhaps if family doctors were the ones to interact with the justice of the peace along with the families, it might make it more comfortable to be dealing with someone we're familiar with.

M^{me} France Gélinas: More comfortable than what you had to go through?

Ms. Victoria Long: Yes.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Victoria. Thank you very much for coming today. Your presentation was appreciated.

Ms. Victoria Long: Thank you, and thank you to the committee.

The Chair (Mr. Kevin Daniel Flynn): Before the members run out the door here, there are two points I'd like to make. We can either do this in a subcommittee meeting or we can do it really briefly now with the full committee. It should only take about a minute. We have a group, the Ontario Association of Non-Profit Homes and Services for Seniors, which asked to appear before the committee in June. Somehow their request was not accommodated, for whatever reason. They've asked to appear as an expert group. Is there any objection to that? We'll try to squeeze them in as the schedule fits.

Mrs. Liz Sandals: So for the 15 minutes?

The Chair (Mr. Kevin Daniel Flynn): They're asking to appear as an expert group and they would get 30 minutes, then. That's what they asked for in the first place.

Mrs. Liz Sandals: We have denied some other folks who had asked to be experts.

The Chair (Mr. Kevin Daniel Flynn): Okay, and some we approved.

Mrs. Liz Sandals: We're getting into dicey territory.

The Chair (Mr. Kevin Daniel Flynn): Yes. Well, we can do it as a subcommittee if you prefer, if you think it's going to be a anything controversial.

Interjection.

The Chair (Mr. Kevin Daniel Flynn): It's the Ontario Association of Non-Profit Homes and Services for Seniors. They represent not-for-profit long-term-care homes and housing. They deal with a lot of older adults with mental illness, challenging behaviours, dementia and chronic disease. These would be the people on the

front lines every day, dealing with some of the older people in our society.

Interjection.

The Chair (Mr. Kevin Daniel Flynn): Yes, I kind of agree. Is there any objection?

Ms. Helena Jaczek: They're certainly an excellent group.

The Chair (Mr. Kevin Daniel Flynn): Yes, very good. Okay, we'll try to accommodate them somehow.

Two dates to remember: The one is October 7. We're all getting together as a group, and there will be an agenda coming out to you about a week before that with some options that we'd like you to think about as to where we go next with the committee. And around the end of November—it's been suggested November 20 or November 22—we'd like to get together, if possible, for a lunch with the minister's advisory group again. That will be on the Friday. I can probably go to that date right now—the date that's being considered right now, anyway; it's not written in stone. It would be November 20.

Ms. Sylvia Jones: I cannot do that.

The Chair (Mr. Kevin Daniel Flynn): You can't do the 20th?

Ms. Sylvia Jones: I know that now.

The Chair (Mr. Kevin Daniel Flynn): Okay. Well, we'll see if we can find a date that's more—is there anybody else who could not do the 20th? This is with the minister's group. It's a lunch or a joint meeting like we had before with the—

Interjection.

The Chair (Mr. Kevin Daniel Flynn): November 20. It's a Friday.

M^{me} France Gélinas: I forgot my BlackBerry, so right now it looks pretty good.

The Chair (Mr. Kevin Daniel Flynn): Anyway, let's give that some thought. The seventh is already set.

Just to tell you that research will be sending you out some options about a week before that, so if you can find a chance to give that a little read, that meeting is going to set the direction for the fall and for the eventual preparation of our report. It's still our intent, I think, to issue an interim report sometime late this year or early in January. Okay?

We're adjourned. Thank you. Oh, sorry, Sylvia.

Ms. Sylvia Jones: One of our presenters, Vincent, raised this on his second page and he didn't get to it: "The Standing Committee on Social Policy was authorized by the Legislative Assembly of Ontario ... to review the personal health information act..." I wonder if the clerk could give us an update on where that is with that committee.

The Chair (Mr. Kevin Daniel Flynn): Okay, we'll make sure we get that.

We're adjourned again. Thank you, and thank you, all members of the public who came today.

The committee adjourned at 1813.

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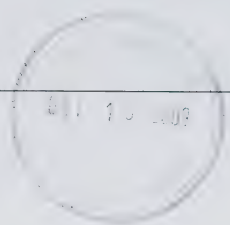
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Official Report of Debates (Hansard)

Wednesday 30 September 2009

Journal des débats (Hansard)

Mercredi 30 septembre 2009

Select Committee on Mental Health and Addictions

**Mental Health
and Addictions Strategy**

Comité spécial de la santé mentale et des dépendances

**Stratégie sur la santé mentale et
les dépendances**

Chair: Kevin Daniel Flynn
Clerk: Susan Sourial

Président : Kevin Daniel Flynn
Greffière : Susan Sourial

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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

SELECT COMMITTEE ON
MENTAL HEALTH AND ADDICTIONSCOMITÉ SPÉCIAL DE LA SANTÉ
MENTALE ET DES DÉPENDANCES

Wednesday 30 September 2009

Mercredi 30 septembre 2009

*The committee met at 1601 in committee room 1.*MENTAL HEALTH
AND ADDICTIONS STRATEGY

MRS. H.M.

The Chair (Mr. Kevin Daniel Flynn): If I can ask the members to take their seats, we'll try to keep on schedule here. We've got a presenter at 4 o'clock, and we're a little bit beyond that now.

If we can call to order, our first presenter this afternoon is Mrs. H.M. Would you like to come forward? Please make yourself comfortable. Choose any seat you like. There's some water there if you need some. All our presenters are being given 15 minutes, and you can use that any way you see fit. Should you leave some time at the end, we can share that among all the parties that are here for some questions and answers, but it's entirely up to you.

Mrs. H.M.: Okay. We're not waiting for everyone to come or—

The Chair (Mr. Kevin Daniel Flynn): You know what? They will trickle in. In fact, they're still coming in behind you as you speak. We do have a quorum, and I would like to keep us on schedule.

Mrs. H.M.: Do you want me to start?

The Chair (Mr. Kevin Daniel Flynn): If we can have everyone's attention, and perhaps we can close that door behind us so we have the full attention.

I'll let you know when there's about a minute left.

Mrs. H.M.: A minute? Okay.

The Chair (Mr. Kevin Daniel Flynn): Yes. Okay? We're all yours.

Mrs. H.M.: Thank you for inviting me to speak to you today. I am actually here today as a mom. My son was born six years ago, and from day one he suffered from severe gut pain, explosive bowel movements, sleep deprivation, fevers, rashes, no eating, no expressive or receptive language until two and a half years of age and stare-offs. We saw 14 medical doctors in Ontario over two and a half years, as well as nine other supporting professions, like speech-language pathologists and so forth, and got no answers, no help, no diagnosis. I did research for myself and decided that we needed to take our son to the United States for treatment, which we did. I am here to speak about personal experience; I do not have a medical background.

The statistics for autism right now: One out of 100 children is getting diagnosed in the States; one out of 60 in the United Kingdom. Canada doesn't even track it, but it's likely to be similar. There is a 10% to 17% increase every year. Boys are four times more common than girls to get it. More children have autism spectrum disorder than cancer, AIDS, Down syndrome and diabetes combined, and the lifetime cost to care for these individuals is \$3.2 million each. The old model, which is what you're probably familiar with, is that autism is a genetic disorder, that it's hard-wired and characterized by behavioural issues. But here I am today to talk to you about the new model of autism.

There's been a significant paradigm shift over the last—more than a decade now—where it's considered to be a genetic predisposition with environmental triggers affecting the body and the brain, with a lot of metabolic problems. What the Defeat Autism Now group in the States, out of the Autism Research Institute in California, does is address the underlying medical problems that these children have. These children are physically ill, and their illness is treatable with appropriate biomedical intervention. But this is done in the States; it's not available in Canada. Most of the children who are treated biomedically improve, and some even recover. There is no cure, but some of these children have recovered. So the old model is that this is a mental disorder; our group views this as an environmental disorder.

What I would like to propose is that, as you're looking to rejig the system, you shift the focus from a disease-centred model to a patient-centred model, which is what this group of physicians does: looking at the whole person rather than an isolated set of symptoms; looking at the interactions between the genetics, environment and lifestyle factors that can influence long-term health and complex chronic disease.

So we're looking at vicious cycles with these children—and not just with the children. This is applicable to many chronic conditions, and that's what I'm hoping to share with you today. With the kids, we're looking at gastrointestinal problems, immune system problems, toxicological problems, neurological problems and problems with their endocrine system, and all of these issues are in systems that are intertwined, so we need to look at it from a systems perspective, a whole-body perspective. Genes load the gun with a genetic predisposition, with autoimmunity in the family, allergies, sensitivities to food and environment and also hormonal imbalances, but

environment pulls the trigger: food, water, air; heavy metals, chemicals, pesticides and plastics that are surrounding us; medications, vaccines, viruses, bacteria, parasites, yeasts and moulds. In your PowerPoint presentation, I put just some conclusions of a few studies that have linked mercury and other environmental toxins to autism.

So the key to treatment is looking at the individual. We're all unique. One size does not fit all. We're looking for individual biomarkers and vulnerabilities to address through customized treatment; every treatment plan is different for every individual. The child is the best lab. There is no magic bullet for this. And I think that one of the reasons why this project in the States has been so successful is that researchers, clinicians and parents work as partners.

This would be of interest to you today, I hope, because it also is applicable to other chronic medical conditions. Many of the psychological conditions that you're focusing on are amenable to the same sort of treatment: Alzheimer's disease, bipolar disorder, schizophrenia, depression and other psychological disorders. There are also other chronic medical conditions: cancer, Parkinson's disease, diabetes, obesity, allergies, MS, reproductive disorders and so on.

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So, getting back to autism and looking at autism as a medical disease: It's not a psychiatric disorder, and therefore the Ministry of Health needs to take back responsibility for the children who have developmental problems.

The Ministry of Children and Youth Services does not have the mandate, the resources, the medical knowledge, the medical expertise or the funding to provide our children with the necessary medical care that they need.

The medical care of seniors with Alzheimer's is not overseen by the Ontario Seniors' Secretariat, and patients with Alzheimer's and patients with ASD have the same underlying medical problems.

Barriers to treatment—the primary one being the label of “autism.” It precludes kids from getting the necessary medical care that they need. Their underlying medical problems are not investigated. Many of them are suffering. Doctors and other providers are uninformed about what to do with them. And no one is taking responsibility for really helping these children.

Families are deterred from trying medical treatments by people who have not even looked into it themselves, let alone done it themselves. OHIP labs are outdated. The doctors don't want to adopt complicated patients who take too much of their time. It's impossible to get referrals to specialists when the doctors we're trying to get them from don't even understand what we're talking about.

The biochemistry is too complex for a 10-minute OHIP appointment in this complex, fragmented system. And in Canada, we can't even purchase the care that we need for our children. Another problem is that we have a lot of double standards with off-label treatments for these children that are not applicable to other conditions.

From the perspective of finances, it's very expensive for families to fund this. Access to treatment is entirely dependent on a family's ability to pay. If the family does not have money, the child does not get treatment and the child has no chance for recovery.

Catastrophic drug costs are deemed to be 3% of household income, but autism medical costs exceed 100% of household income. This includes consultations, lab work, couriers, supplements, medications, occupational therapy equipment, speech and language therapy, travel, accommodation, duty, shipping costs—just shipping things back and forth across the border increases costs by about 50% through taxes.

Overall, it costs Canadian families who are going down to the States about double the cost that Americans pay to treat their children.

Private insurance plans cover nothing in the States. Our RRSPs, when we cash them in to pay for these treatments, are taxed heavily so we have less principal to cover the medical costs for our kids. There is very little government funding available, if any at all, and there are very long wait-lists.

The HST that's going to be implemented is going to increase our costs significantly and take away from the money that we have to spend on our children for their health care. So the government is going to be making money from the fact that our children have medical needs that are unmet.

We can't claim many expenses on our income tax, like nutritional supplements, which are a key part of it, and diet.

The special services at home program, if people are able to get it, provides respite only. There's no money for treatment.

It is my understanding is that in Alberta, for each child who's diagnosed with autism, the family is given \$80,000 to spend as they choose, be it on ABA, biomedical, far infrared saunas and so forth.

This is a human rights issue. Patients with the same underlying medical problems but without the autism label are entitled to treatment covered by OHIP. These children's basic medical needs are not being met.

Steve Edelson, the director of the Autism Research Institute, says, “All men are created equal, except if they have autism.”

The Canadian Cancer Society sent out a report last week, saying that all Canadians must have access to drugs without financial hardship, because the person needs to focus on their health and shouldn't have to worry about how they're going to pay for their health care. The federal and provincial ministers are already addressing this. What about our families?

Urgent action is needed. The government needs to acknowledge that there's an epidemic. They need to allocate appropriate resources like we have for the H1N1 flu, AIDS, SARS, cancer and diabetes.

We need to ask why this is the sickest generation ever and the first generation that's likely not going to outlive their parents.

We need to transfer the kids to the Ministry of Health from the Ministry of Children and Youth Services now and not wait until this report is done.

We need to provide OHIP coverage for medical treatments now. And we need to train doctors and revamp medical schools so people are educated in the biomedical or functional medicine approach.

We need to invest heavily in new labs. The \$1 billion spent on eHealth might have been better spent on increasing our ability to identify the biomarkers in all people with chronic conditions.

I'd like to ask for your help to stop proposed federal legislation that is going to restrict access to nutritional supplements, which is a key part of the biomedical approach. We don't need to use drugs. We're looking at nutritional deficiencies and how that all blocks up the system and makes it unable for children to detox the mercury, lead, arsenic, aluminum and pesticides from their bodies.

We need to clean up the environment, our food, our water and our consumer goods. We're poisoning our kids and ourselves. We need to provide them with early and continued intervention because it is shown that is where you get the best outcomes. We need a department at the public health agency of Canada to develop a strategic plan and collaborate with the DAN doctors in the States to get them up and running and not duplicate efforts.

We need to fund meaningful research that's going to help people now and study the children who have recovered to see why they recovered, how they recovered. We need to broaden the disciplines involved like toxicology, immunology, gastroenterology and endocrinology. Right now, no one thinks they're responsible for these children.

We need to investigate the health outcomes of vaccinated versus unvaccinated populations, and this study has not been done.

I'd like to invite you to attend the Autism One conference that is taking place at the end of October. This is the first time that many DAN practitioners are coming from the States; many key people are coming up here and it's a great opportunity for all Canadians to see what's being done in the States and see how we can bring that up here and help our children.

The kids are the product of the current system and it's not working, and tinkering is not going to help with this system. Our doctor in the States says, when trying to figure out what tests to do, "Don't bother wasting money doing something unless it's going to change our approach to treatment," and I hope that the same will be done with this group. I'd like to see that the money be spent to improve the knowledge at the labs and covering treatment options and helping to clean up the environment, and overall, to prevent chronic conditions.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much. We've got about three minutes left, so probably time for a very brief discussion, if you're up to it.

Mrs. H.M.: Oh, sure.

The Chair (Mr. Kevin Daniel Flynn): We'll start with Christine.

Mrs. Christine Elliott: Thank you very much for joining us today. We have had the opportunity to discuss the issues that you've raised in committee today on several occasions, so I'm very familiar with the things that you're speaking about.

I think it is fair to say that because we don't really know what causes autism—we don't even know how to categorize it right now—I think that we need to be open to a number of approaches with respect to treatment. Certainly you've raised our level of awareness with respect to these issues and we take them very seriously. I have been provided the information with respect to this conference. I do hope to be able to attend at least part of the conference.

Mrs. H.M.: Great. Thank you very much.

The Chair (Mr. Kevin Daniel Flynn): Peter, any comments?

Mr. Peter Tabuns: Thank you for the presentation. It's quite comprehensive.

You made a comment and I just want to make sure I heard it correctly: Ontario does not at this moment track people with autism, so we don't have reliable statistics. Did I hear you correctly?

Mrs. H.M.: Ontario and Canada. At Health Canada they have departments for diabetes, cancer and AIDS, but there is nothing there for autism. We do not even know how many kids are affected here, so we always go by the American figures, and even all the studies that are done there always reference the American Academy of Pediatrics. Canada has no ownership over anything.

Mr. Peter Tabuns: That's very disturbing. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Helena.

Ms. Helena Jaczek: Thank you, as well. I have actually attended a DAN conference in the past, in the US, having been on a board of a school for children with autism.

Obviously, a very complex issue. You've made a number of recommendations. If you had to choose the most important thing that you would want to see done in Ontario, could you say what that number one priority is?

Mrs. H.M.: To look at the underlying medical problems these children have and address them now.

Ms. Helena Jaczek: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Just from the Chair, then, if I took one thing from your presentation, with all the discussions that all parties are engaged in around IBI and ABA, what you're saying is that they treat the symptoms, but we're not getting to what is actually causing the autism in the first place. Is that accurate?

Mrs. H.M.: Yes. What they have found is that if you treat the underlying medical problems these children have, they're better able to benefit from their other therapies. So when you have a child who's in severe pain from gastrointestinal problems and who can't focus, or you've got some child whose brain cells are actually being killed by excitotoxins in glutamate and MSG and

having brain fog because of food sensitivities, they can't think. For my son, no receptive or expressive language abilities at two and a half years of age; we took gluten and casein out of his diet—those are the proteins from dairy and grains—and within one week he was doing sign language and within one month he was talking.

The Chair (Mr. Kevin Daniel Flynn): That's fascinating.

Mrs. H.M.: But we still had to take him to the States for speech therapy because the same type is not done up here.

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The Chair (Mr. Kevin Daniel Flynn): Is this view accepted in the Canadian medical establishment yet or is it fairly cutting-edge?

Mrs. H.M.: It has been used in the States. They started it in the 1960s. The Autism Research Institute has really been ramping up the last 15 years or so as more children have been affected, and more doctors' children have been affected, so more doctors have joined the fold.

In Canada, I'm aware of two physicians who are doing this but not to the degree that it's being done in the States.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today. That was an excellent presentation.

Mrs. H.M.: Thank you so much.

JANE MEDERAK

The Chair (Mr. Kevin Daniel Flynn): Our next call today is a conference call. It's from Jane Mederak. Is Jane on the line?

Ms. Jane Mederak: Yes, I'm here.

The Chair (Mr. Kevin Daniel Flynn): Hi, Jane. How are you?

Ms. Jane Mederak: I'm just great. How are you?

The Chair (Mr. Kevin Daniel Flynn): We're all doing wonderful. We just had a great presentation, and you're presenting next. I'll tell you who's in the room with us. There are a number of members of the public. There's Christine Elliott, from the Progressive Conservative Party, who's the Vice-Chair of the committee; Peter Tabuns is sitting in today from the NDP in place of France Gélinas; and Jeff Leal, Helena Jaczek and Bas Balkissou are here from the Liberal Party. I'm Kevin Flynn; I'm the Chair. You've got 15 minutes. We can hear you very clearly. You can use that 15 minutes any way you see fit. If we've got a little bit of time at the end, perhaps we can engage in some questions and answers, but that's entirely up to you.

Ms. Jane Mederak: Questions and answers are great if there is time. I think there might be.

The Chair (Mr. Kevin Daniel Flynn): Okay. If you can talk a little bit more clearly, I think we'll be fine.

Ms. Jane Mederak: If I'm not talking clearly enough—am I talking too loud or too quickly?

The Chair (Mr. Kevin Daniel Flynn): No. Right now you sound great.

Ms. Jane Mederak: Okay. I'll try to keep that up, then.

Thank you very much for allowing me to speak to you today by telephone. My name is Jane Mederak. I am 66 years old and am probably one of the few people who have been diagnosed with Alzheimer's and who's happy with the diagnosis. After my diagnosis and start of medication, and experiencing a huge, happy and wonderful change in myself, I started to tell my family, friends and co-workers about my journey in the Alzheimer world.

When I first told my story, their faces were very sad and horrified. It seemed to me they thought that what I had was the very worst thing to have acquired, not something to put a smile on my face about.

I was baffled, and it took a while to understand why I was getting this reaction, but I thought, "I'm not sick in bed, I still work a little in real estate with my partner, I'm still on the right side of the grass, and if I listen to my doctor and behave, I may be like this for a very long time." I could have danced in the street.

But most people question my diagnosis and wonder if it is just in my head, or if maybe I'm one of those people who like to be sick and seem to always get the latest and worst ailments to be had. But that's not me.

This is how it all played out in my life. Back in 2007—we say 2007, but I think it's about four years ago—my husband, Rick, and I spent the months of December and January in Melaque, Mexico, and I was my normal, happy self. We arrived home at the beginning of February, and I was still a really happy person. I felt anxious to get back into my real estate business and reconnect with my clients.

As I eased back into my life here, it became evident that I was starting to get forgetful. It was quite funny at first, and then I became embarrassed at my mistakes when talking to people, or I would get partway through saying something and I would suddenly go blank and couldn't continue. I would say, "I can't remember," and change the subject. This is okay with friends and family but not okay when talking to my real estate colleagues and customers. I was forgetting more times than remembering.

Also, my head felt like there was a fog inside it. Sometimes it is very thick and sometimes it gets quite clear, and sometimes I have a quick dizzy feeling. I also started to get quite weepy and cried at the drop of a hat, which is not at all like me. I'm used to being strong, working hard and long hours and being very on top of my business world. The new me was now afraid to go into the office, and seeing customers was very stressful.

With hindsight, I think my first experience with memory loss happened about four years ago, when I sold a house in Paris for an old customer and had my own offer competing with another offer from another real estate office. The vendor was an older gentleman, who was one of my oldest customers. I really liked him and he really liked me. Over the years I have mailed out funny postcards to my clients each month so that they would remember me if they needed a realtor. I was amazed

when this old gentleman showed me that he had saved them all. On offer presentation night, the other realtor had dropped off his offer and it was there when I arrived. I never did see him or talk to him face to face. Both offers were presented and the vendor decided to accept my offer. He had met my client and liked her.

As time went by, I was notified by the Real Estate Council of Ontario that my client's sister had complained about me and a file had been opened and an investigation started. They wanted many questions answered, among which was to know who was the other agent, and I couldn't remember. I even called a few realtors and asked if they were the other agent but was never able to solve that mystery—nothing like feeling foolish when I was doing that, let me tell you. This process of calling other agents was very degrading to a proud, successful realtor like me. The RECO investigation was eventually closed, and they decided that I was not guilty. However, the experience, after being in this business for 25 years at that time, was awful. I have other notes about other occurrences. None are as bad as this one was, but it did make me pay attention to my memory and notice how very forgetful I was becoming.

My first attempts to find out if I had Alzheimer's were frustrating, even to the point of being turned away from the Alzheimer's office in Brantford. I then attended a talk by Dr. Braun, an Alzheimer's specialist, with my daughter Lisa and her mother-in-law, Sylvia, who's a nurse. Sylvia asked me after the presentation if I could draw the face of a clock. I said, "Sure." She said, "Well, then, you don't have Alzheimer's." However, I decided that I needed to see my own GP, who referred me to Dr. Braun, who after a period of time and many, many tests diagnosed me with early-stage Alzheimer's and started me on medication that allows me to live a very happy, normal life today.

Rick and I now live for six months of the year in the summertime in Paris, Ontario, and six months of the year in the wintertime in Melaque, Mexico. It's a very simple, wonderful life of sunshine, warm sand, water exercises, walking everywhere, eating very healthy food, learning to play mah-jong—big mistake—learning Spanish, learning to play my new guitar and seeing all our great friends again.

Oh, crap—I was typing as I was thinking this out when I was writing it and I just kept on typing—I forgot where I was going with this, but one thing's for sure: My husband, Rick, is a happy guy. This is a little off colour and I hope you don't mind, but I can never remember if we had sex last night or last week, and I think we make love a lot more than we ever did: one of the few benefits for my other half and a great benefit for my brain.

What could make my life even better? Actually, a change in attitude regarding Alzheimer recognition and diagnosis. People like me need help sooner. Let me try to explain. I am any Jane thinking I have a memory problem. I go to the Canadian Alzheimer site and look for warning signs, and here they are:

"(1) Memory loss that affects day-to-day function," and then it explains: "It's normal to occasionally forget

appointments, colleagues' names or a friend's phone number and remember them later. A person with Alzheimer's disease may forget things more often and not remember them later, especially things that have happened more recently." This is not a description of me. I'm completely normal until, and only until, I get stressed. I can go for weeks without being stressed. In fact, I work hard at not being stressed. I am very protective of my brain and work hard to stay clear of stressful situations.

"(2) Difficulty performing familiar tasks:

"Busy people can be so distracted from time to time that they may leave the carrots on the stove and only remember to serve them at the end of a meal. A person with Alzheimer's disease may have trouble with tasks that have been familiar to them all their lives, such as preparing a meal." This is not a description of me. When we're living in Paris during the summer we're constantly having friends for dinner, and I seldom have problems cooking or entertaining. Recently, there was a bit of a disaster when I was preparing a dinner for my friends. The dinner was five courses, and the recipe was from an old gourmet magazine and had very faint small print and multiple pages. I became confused at times and frustrated at times and vowed never to cook that menu ever again.

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"(3) Problems with language: Everyone has trouble finding the right word sometimes, but a person with Alzheimer's disease may forget simple words or substitute words, making sentences difficult to understand." This very seldom happens to me. I still have my real estate licence, now work with my partner and absolutely love visiting my old faithful customers. It's a highlight of my day, and conversations are very easy for me.

"(4) Disorientation of time and place: It's normal to forget the day of the week or your destination—for a moment. But a person with Alzheimer's disease can become lost on their own street, not knowing how they got there or how to get home." This also does not describe me. I would never get lost on my own street, but the reason I'm not there with you is that to take the train to Toronto and get off at Union Station and find my way to a taxi etc.—yikes, it could have been a disaster. I value my brain function and protect it with all my might—I, who used to be on the board of directors of the College of Massage Therapists of Ontario as a public person, when my most interesting job was that of being the judge at discipline hearings for the college. During this time, I travelled to Toronto on the train frequently. Thank you for letting me talk to you by telephone today.

"(5) Poor or decreased judgment: People may sometimes put off going to a doctor if they have an infection, but eventually seek medical attention. A person with Alzheimer's disease may have decreased judgment, for example, not recognizing a medical problem that needs attention or wearing heavy clothing on a hot day." I am happy to say that I have never worn my bikini on the street in the winter. I may someday, as my journey progresses, but this is so far from being a problem for me that I won't waste time talking about it.

"(6) Problems with abstract thinking: From time to time, people may have difficulty with tasks that require abstract thinking, such as balancing a chequebook. Someone with Alzheimer's disease may have significant difficulties with such tasks, for example not recognizing what the numbers in the chequebook mean." I told you my real estate story at the beginning about my memory loss. In hindsight, I am very happy that this happened to me. To have such a profound insight into my failing memory at such an early stage is like a gift from God. To be able to get help this early is totally amazing. Please don't let me down. Please change the warning signs because there are lots more people like me out there.

"(7) Misplacing things: Anyone can temporarily misplace a wallet or keys. A person with Alzheimer's disease may put things in inappropriate places: an iron in the freezer or a wristwatch in the sugar bowl." I'm sitting here laughing at this one because I lost my car yesterday. I was working at our huge church fall fair in the book boutique. When I arrived, I parked at the back of the building to save the good parking spots for customers. At the end of the day, when it was pouring rain, I said goodbye and went to get into my car, except I couldn't find it. I went into the building where my husband was working and couldn't find my husband. I started to cry. Father Steven saw me, put his arm around my shoulder and said, "Let me help you". We went back to the book boutique building and started to look around. At the back of the building was my car. Oh man, did I feel foolish—another Alzheimer's moment.

"(8) Changes in mood and behaviour: Everyone becomes sad or moody from time to time. Someone with Alzheimer's disease can exhibit varied mood swings—from calm to tears to anger—for no apparent reason." See above.

"(9) Changes in personality....

"(10) Loss of initiative." Both of these things affect me only very mildly. Therefore, I thank my lucky stars every day that I screwed up only one real estate transaction and called for help immediately.

Thank goodness I have great docs like Dr. Jeff Manning and Dr. Ann Braun who listened to me, tested me and gave me an early diagnosis.

When I tell people that I have early stage Alzheimer's, they look at me so sadly, but I want to shout, "Stop! I'm still leading a very normal life. I'm so lucky. Just think of all the horrible diseases that I could have." Every six months Dr. Braun tests me, and for every test so far I have scored better. The drugs are doing their job and I still get to dabble in real estate with my partner in the summer and travel and live in Mexico for six months in the winter.

Please, please take the stigma away from Alzheimer's disease and promote early detection—and change the warning signs, also. Imagine a world like mine for everyone suffering memory loss. Imagine them living with their loved ones for many years. Imagine the savings of keeping them in their homes much longer and happier with their families. Please take the stigma of Alzheimer's away.

The Chair (Mr. Kevin Daniel Flynn): Jane, thank you very much for your presentation. You used your time very, very wisely. Unfortunately you used it all up, so we're not going have any time for questions and answers.

Ms. Jane Mederak: That's okay.

The Chair (Mr. Kevin Daniel Flynn): You can't see everybody in the room, but I can tell you everyone was listening very attentively, including the members of the public. You certainly got your point across.

Ms. Jane Mederak: Thank you. I'm very glad I did, because it's a much happier life. The help needs to be there for people and the stigma needs to be taken away from this disease because it's not a sad thing to have. My life is very normal and wonderful. It's only the odd time that I sink into problems.

The Chair (Mr. Kevin Daniel Flynn): Thank you for joining us today, Jane. It was really appreciated.

Ms. Jane Mederak: Thank you for allowing me to be there.

JORDAN STONE

BOWEN McCONNIE

The Chair (Mr. Kevin Daniel Flynn): Our next presenter today is at 4:30, and that's Jordan Stone. Jordan, would you like to come forward? Make yourself comfortable. Pick any one of the chairs you like.

Mr. Jordan Stone: I just wanted to thank Patricia Teskey—she's with the Schizophrenia Digest Magazine and the Schizophrenia Society of Ontario—Jyll Simmons, who's with CAMH family council; Annick Aubert, who's with the family resource centre; and Susan Allen, who's the director of the family council. They really support what we're doing.

The Chair (Mr. Kevin Daniel Flynn): Okay. Thank you. It's great to have all your friends here.

Let me tell you what the rules are before we start. You get 15 minutes like everybody else. You can use that any way you see fit. If there's any time left over at the end, we'll split it. If you could introduce your colleague as well just so that everybody at Hansard understands.

Mr. Jordan Stone: This is Bowen McConnie. He's another member of the group.

The Chair (Mr. Kevin Daniel Flynn): Okay. It's all yours.

Mr. Jordan Stone: We just want to show a film first. It's four minutes.

The Chair (Mr. Kevin Daniel Flynn): If any members of the public would like to see the film, you could probably see it from over in this corner, here.

Video presentation.

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Mr. Jordan Stone: The reason why we showed that is because it's kind of like a glimpse into the schizophrenia experience, and also to show that our members are very talented. We have three Ph.D.s in the group, artists, musicians and amazing people.

What we're doing is different. Nobody has done this in Canada; I can't speak for the United States, but I haven't found anybody doing what we're doing. I started the first and only diagnostic-specific schizophrenia peer support group and network in the country.

What we have done in five years is save the government tens of thousands of dollars in hospital admissions. Not one of our members has died—and I know that sounds grim, but you know, it's a 1-in-10 suicide rate for schizophrenia, higher than any other mental or physical condition.

We have basically—we just lost our clubhouse. We received maybe four or five donations in five years. I think there's a handout showing about 30 or 35 different mental health organizations we've approached, including the provincial government, for help. We've not received a dime from any of them, with the exception of CAMH, who paid for three months of our rent before we lost our place.

Maybe you can go to our website sometime. On our endorsements page we have some of the top researchers in schizophrenia, doctors and social workers, from the pro- to anti-psychiatry movements, supporting what we're doing.

I guess why I'm here is because although everybody supports what we're doing, they can't help us because we don't fit into anybody's mandate. Basically, what I've discovered is that mental health is a business first, and whoever has the best fundraiser and marketing people and whatever wins.

Nobody has done what we're doing and I know why now: because it's very difficult. We deal with stuff 24 hours a day, seven days a week—crises and the poverty. When you're living at one third of the poverty level and you have nobody to talk to and you've lost everything, sometimes even your family, it's pretty sad. You're basically dealing with that wreckage. Most people with schizophrenia will not talk to other people who don't have it in the same way they will talk to people who do have it because of the shame and stuff like that.

So I guess—

The Chair (Mr. Kevin Daniel Flynn): If you need some water, we've got a glass of water down there.

Mr. Jordan Stone: No, I'm all right for water. I don't need water.

We want to somehow have the government change, shift—how I also figured how it works is, whoever has the money is in control of your care and your life. We've had 30, 40 years of a model that is not working, and we've actually developed our own recovery model which does work. CAMH has recently adopted a model which is a non-diagnostic-specific model coming from the States, which is very well marketed and not very practical.

Everybody is talking about peer support and recovery, but nobody is defining it, and we have. It's not life skills like the program they're doing at CAMH, and it's not just befriending somebody. It's understanding and learning how to manoeuvre a thought disorder or a paranoia or a

hallucination or whatever and be there for somebody when they need you.

We've also developed this thing called psychotic symptomatology, which the PANSS Institute in New York—they're taking what we're doing very seriously. The PANSS scale is the most used rating scale for people with schizophrenia in the world—almost every psychiatrist uses it—and they actually are developing, based on what we've done with our new scale, a new scale for clients.

What we're doing is a little bit more scientific. We want to have best practice statistics, but we have nothing. We've been doing what we've been doing for zero; nobody has been paid anything. All the other mental health organizations out there have staff who are getting paid, okay? We have nothing. Almost everybody's on disability and the few people who aren't are examples to everybody that there is hope.

I guess that's why maybe something can happen so that some time in the future, it's not so difficult. We just lost our clubhouse. We had a donation from a family member that ran out. CAMH helped us with three months of rent and then we got kicked out. The place fit six people; we have 25 members and 85 on the waiting list. The place was a cockroach-infested dive in Kensington Market. The toilets stank. It was cheap, though, and it was all we could afford. This just may be an eye-opener for you people to see that we can do something ourselves. We know what we need and we want to somehow make it work.

I'll just pass this off to Bowen, who has been a member for many years as well.

Mr. Bowen McConnie: Hello.

The Chair (Mr. Kevin Daniel Flynn): We've got about three minutes left, just so you know.

Mr. Bowen McConnie: Jordan Stone has been my friend now for about five years, since the beginning of the group. He's been critical for my ongoing recovery, in sharing knowledge about medication and supporting each other when you decide to change medications or you're going through a difficult period, which I went through. I stayed with Jordan for about a week. I went through a difficult process of changing medications, but now I'm on about one tenth the dose I was on before; I used to be just a zombie.

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Before the group, I had no friends, and now my life is a lot better; my quality of life has improved greatly. Now I have a number of friends who I can talk to and can understand, because we have similarities. Everyone's different in their symptoms, but we think the diagnostic-specific model is very important, especially for schizophrenia, because it's so different than just depression or whatever it might be.

We hope that we could receive support and we would like to have more dignity in having a clubhouse where we could work. Members could get some pay for volunteering—or not have to volunteer, but putting their time in and running the clubhouse. We have high aspir-

ations and we want this to be a model for other places too, other cities across Canada and the world, eventually, that a schizophrenic isn't just a useless drain on society, but has many important things they can contribute and talents. Just having a good clubhouse that can accommodate the number of people who are wanting to be part of this group would definitely save a lot of money for the government in hospital admissions and could ultimately save lives.

I had a suicide attempt and I was pretty overwhelmed with symptoms. I had a lot of people visiting me in the hospital and talking to me and so I didn't feel alone. Eventually, I came out of it and now things are much better. Most of the people in the hospital didn't have that at all and they were just alone, or relatively so. I hope you believe in the diagnostic-specific and could help us.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much, Bowen. Thank you too, Jordan, for the presentation as well and thank you for showing your film. I noticed that you produced and wrote it. Very good. Thank you very much for coming, both of you, today.

Mr. Bowen McConnie: Thanks.

Mr. Jordan Stone: Actually, it was produced by Workman Arts.

The Chair (Mr. Kevin Daniel Flynn): Okay. So you wrote and directed it?

Mr. Jordan Stone: Yes.

The Chair (Mr. Kevin Daniel Flynn): Sorry about that.

ONTARIO ASSOCIATION OF PSYCHOLOGICAL ASSOCIATES

The Chair (Mr. Kevin Daniel Flynn): Our next presentation today is the Ontario Association of Psychological Associates. We've got Caroline Koekoek and—somebody I know very well—Tina Agrell. Welcome, Tina. Good to see you. Like the previous presenters and all of those today, everybody gets 15 minutes. You can use that any way you see fit. If there's any time at the end for any questions and answers, we'll split that amongst everybody. There should be some clean glasses there if you need any water. It's all yours.

Ms. Caroline Koekoek: Yes, I think we're good to go. Can everybody hear me okay? My name is Caroline Koekoek. I'm the president of the Ontario Association of Psychological Associates, the OAPA. With me is Tina Agrell, our vice-president. I work for the Halton District School Board and supervise professional staff in a variety of disciplines, and Tina is in the psychology department of the Peel District School Board.

On behalf our association and its members, I'd like to thank the Select Committee on Mental Health and Addictions for inviting us to present some of our perspectives and recommendations today. We sincerely hope that the committee, along with other government bodies that are engaged in various consultations on this issue, will be successful in moving the mental health and addictions agenda forward. For those of us who work in the mental

health sector on a daily basis, we recognize that the system needs to be improved and we believe that in fact it can be improved.

What is a psychological associate, I suspect you may be wondering. We are regulated health professionals whose title came into being in 1993 with the proclamation of the Regulated Health Professions Act. Psychological associates are registered members of the College of Psychologists of Ontario on the basis of appropriate academic training in psychology at the master's level, successful completion of rigorous written, oral and jurisprudence examinations, and at least four full years of professional practice as a provider of psychological services. Psychological associates practise autonomously in areas such as counselling, clinical, school, industrial, organizational and neuropsychology. We perform assessment, consultation, research and other services in a wide variety of settings such as schools, hospitals, social service agencies and private practice. The scope of practice for a psychological associate is identical to the scope of practice of a psychologist. Therefore our college has two titles, one scope of practice.

At the present time there are approximately 500 psychological associates working throughout the province. The vast majority of these are engaged in the direct delivery of mental health services.

We have some recommendations for you today:

(1) Access to existing mental health services is an ongoing, problematic issue that needs to be resolved. Clearly we should be doing a better job of connecting people suffering from mental health and addictions to existing programs, and I'm sure that the committee has heard a lot about the issues of access from many people over the last several months. If an individual has a physical problem, they know, of course, that they can go to a doctor's clinic with the expectation that this ailment will be assessed and treated in some way. Assuming that an individual is aware that they have a mental health issue, the question of where to go for treatment and whom to get it from is much less clear. This lack of clarity can be extremely problematic for vulnerable individuals.

The OAPA is completely supportive of the family health teams, based as they are on the notion of an integrated service delivery model, and strongly urges the government to adequately fund positions for psychologists and psychological associates so that patients with mental health and addiction issues are assessed and treated on a timely basis and in a cost-effective manner. In terms of the current lack of mental health services in northern communities, we strongly recommend that there is permanent, ongoing funding allocated for full-time psychological associates and psychologists in the family health teams in those areas.

Integrating mental health with other health services at the point of entry will allow more individuals to be diagnosed and treated. Doctors, nurses and other health professionals will also have the support and education they need to be able to fully treat the patients with physical and mental health as well as addiction issues.

(2) The OAPA strongly recommends that the government increase its support of the mental health workforce. One of our key recommendations, and one which we have been advocating over many years, is the streamlining of the titles in psychology. Currently there are two titles. We propose that there be only one. This would involve no monetary cost to the government whatsoever.

As an association, we have spent an enormous amount of time and resources attempting to educate government agencies responsible for establishing programs and policies about psychological associates and that our scope of practice is the same as that of psychologists. Our entire advocacy on this issue is a response to our members, who are constantly thwarted in their attempt to deliver psychological services by the fact that the title "psychological associate" is neither understood nor even remotely seen as equivalent to the other title in our college. This issue has created a substantial barrier to access, and we routinely see clients turned down in their applications for mental health services or for funding because they are seeking treatment or diagnoses from a psychological associate versus a psychologist. In other cases, a client might not even understand that a psychological associate is in fact a regulated health provider, whereas for another title, such as senior clinician, people may have a connotation of that title that it is a regulated title, and it isn't.

1700

The government has told the OAPA over the years that we should continue to educate ministry staff who are involved in establishing policies and programs in the mental health area so that they understand that there is one scope of practice in psychology. We have done this and we will continue to do this, but it's our hope that the government takes some responsibility for ensuring that they themselves know what they're doing.

Our recommendation is simple: one title for all members of the College of Psychologists. This would alleviate a significant distress on the part of providers and clients alike. It would certainly save considerable resources for both the OAPA and government officials, and they wouldn't have to answer all my calls and e-mails and visits. It would also provide absolute clarity to families and individuals seeking mental health and addiction services from providers in psychology.

(3) Related to the issue of title, we have again the current application of Bill 179, the Psychotherapy Act. It's our recommendation that the government proceed with caution in its application of Bill 179, as the current direction taken by the Ministry of Health and Long-Term Care suggests that more confusion is being created in the mental health sector. This confusion is in part around access to the title of "psychotherapist." The current changes to the RHPA would see this title limited to members of a new college, the College of Psychotherapists, although other people will have access to the controlled act of psychotherapy. But to date we have no sense of what the entry-level qualifications will be to this new college.

Members of other colleges, such as the College of Psychologists, would have to use the college title to precede "psychotherapist." Therefore, if the psychological associate is treating a client via psychotherapy, the member would need to be referred to as "Jane Doe, psychological associate, psychotherapist." If you didn't need therapy before, you might when you're trying to figure out who everybody is in all of this.

We feel this is needless confusion for the client. If "psychotherapist" is a meaningful term for clients, we believe that any regulated health profession with access to the controlled act of psychotherapy should be allowed to use the unencumbered title of psychotherapist.

Now I'm going to turn it over to Tina.

Ms. Tina Agrell: Thanks, Caroline.

(4) The other key recommendation we'd like to make today concerns the acute lack of graduate programs in psychology, particularly at the master's level. We'd like to ask you to encourage universities to offer joint degrees in psychology and something applied, like social policy or public health or economics. The lack of capacity in graduate programs, particularly school psychology and clinical psychology, has directly led to a well-documented shortage of practitioners, so that positions in school boards across the province stay unfilled, to the detriment of children and families suffering from mental health issues. We know that children and youth who receive treatment for mental health issues, such as severe depression, have a remarkably high rate of successful treatment and go on to be successful students and members of the workforce.

School psychology staff are the key link in the system, as they are able to assess, diagnose and treat children with mental health issues. If not for the work of school psychologists, many children experiencing mental health issues across the province would go undiagnosed and untreated. You might broaden the role of psychology in school boards and hospitals to permit longer-term interventions in the form of cognitive behaviour therapy and counselling. The OAPA strongly recommends that the government increase the number of graduate places in psychology at both the master's and Ph.D. levels at Ontario universities.

(5) The OAPA strongly urges the government to fill the gaps in the provision of programs for youth with mental health and addiction issues. In-province funding for drug rehabilitation programs for youth needs to be increased, and the complex funding structures for youth who are dually diagnosed with, for example, an intellectual disability and a mental health issue need to be streamlined so that the necessary treatment is accessed and delivered in an integrated and seamless process. Currently, it is in many instances easier to obtain funding for out-of-region placements than to provide support within the home community so that families can stay in close proximity during their crisis.

Do you remember the young boy who died of exposure after running away when his parents banned his video games? You might establish a centre of excellence

here in Ontario with a pool of knowledge and expertise around gambling and gaming addictions. You might establish a triage system in municipalities, with phone-in central intake, case managers for links and referral to local agencies. You might set up health clinics in isolated communities, with psychological services on-site.

(6) Our last recommendation is that the government look at extending OHIP provisions to cover the costs of therapy from psychologists and psychological associates. This would be a dramatic, systemic change that would signal that we, as a society, understand and accept that mental health and addiction is a central health issue whose treatment demands as much of our attention and resources as do medical conditions like heart disease, cancer and other physical ailments.

As the committee has been hearing over the last several months and as recently as 10 minutes ago in its consultations, mental health problems and addictions debilitate, create enormous human suffering and, in many instances, can lead to premature death.

Remember those scruffy figures shambling around Parkdale and sleeping on gratings? They are someone's lovely daughters, husbands, mothers, brothers. You could introduce co-location to provide subsidized housing with a nurse practitioner, psychological therapy, job skills training, and support for daily living skills, all on-site.

In conclusion, we recognize that members of the Select Committee on Mental Health and Addictions and the minister's advisory council have been receiving an enormous amount of input from mental health and addiction experts, front-line service providers and numerous organizations representing the mental health and addictions sector, all of whom are committed to serving their patient populations.

The OAPA has highlighted some of the fundamental issues that its members have faced over the years in their efforts to deliver exemplary mental health service, and we trust that the select committee and the government will give them its most serious consideration. After all, to know and not take action is not to know at all.

Thank you for your time. We wish you all every success in dealing with this very important issue.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Caroline and Tina. There is time probably for at least one question, maybe two. France, did you have anything?

M^{me} France Gélinas: I was not aware that two professionals with the same scope of practice had to use two different titles. I would certainly thank you for bringing that to my attention. This is something that I had not noticed.

When you talk about having psychotherapy services covered under OHIP, do you mean that you want people to have access to those services without paying?

Ms. Caroline Koekkoek: Yes.

M^{me} France Gélinas: You've talked about a family health team model being one—are there psychotherapists right now who work within family health teams?

Ms. Caroline Koekkoek: We know that there are some psychological associates who work with family

health teams. Off the top of my head, I can't tell you if they provide psychotherapy or other mental health-related services.

Ms. Tina Agrell: I think there is a provision of service, entitled PsychAid, where people who are in private practice are actually offering these therapy services, unpaid, on a basis similar to legal aid.

The Chair (Mr. Kevin Daniel Flynn): Thank you. We've probably got time for one very brief question and one very brief answer. Bas?

Mr. Bas Balkissoon: Thank you, Mr. Chair. I just wondered if you could tell us, is there a difference in training between psychologists and psychological associates?

Ms. Caroline Koekkoek: The basic difference is that a psychologist, as our college is now, has a Ph.D., and a psychological associate has a master's degree.

Mr. Bas Balkissoon: Okay. Thank you very much.

The Chair (Mr. Kevin Daniel Flynn): Thank you both for coming today. It was a great presentation.

Ms. Caroline Koekkoek: Thank you for having us.

The Chair (Mr. Kevin Daniel Flynn): We didn't put the jackhammer out on purpose. That was completely inadvertent, but you handled it very classily, just like it didn't happen. Thank you very much for coming.

EWA ZAKRZEWSKA

The Chair (Mr. Kevin Daniel Flynn): Our next presenter today is the 5 o'clock presentation, Ewa Zakrzewska?

Ms. Ewa Zakrzewska: Not bad.

The Chair (Mr. Kevin Daniel Flynn): Not bad for an Irish guy. You've been here from the start so you've seen all the other presentations. You've got 15 minutes. You can use that any way you see fit. If there's any time at the end, we'll split it like we've been doing.

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Ms. Ewa Zakrzewska: Thank you very much and good afternoon. My name is Ewa Zakrzewska. I stand before you as a wife, mother, grandmother, fourth-year student in the family and community social services program at the University of Guelph-Humber and a placement student whose fourth-year role includes that of a groups facilitator at TEACH, an agency that teaches empowerment and advocates for community health.

I am also in recovery, life's journey of change, from a concurrent disorder, a combination of mental illness and addiction, a skill that seemed—I can't understand what I've just written, excuse me, so I'll skip that part.

Thank you for allowing me to speak about my idea of possible improvements to the mental health and addictions care system.

Not long ago, I read this adaptation of an old proverb: "You can care for people for a day. But if you educate people to become involved, you have helped them to care for themselves and others for a lifetime." How true that was for me, but in retrospect, I can ask, "Why did it take so long for me to become educated in recovery?" Unlike

most recovering individuals I have spoken to, I was most fortunate; I was able to use all the resources available for my recovery.

At this time, I could tell you about some of my personal experiences in hell where the fear was constant and the terror just around the corner, not for just an hour or a day, but endlessly for over two years. But I am aware you have heard such stories in the recent past. That information is included in the package I have prepared for your perusal, should you be so interested. In my opinion, there are more pressing areas to cover, namely, key points to be made concerning addictions and mental health care.

(1) First and foremost, I would recommend that your final report be guided by the recovery principle:

"What is recovery to me?"

"Knowledge and understanding of the self."

"Finding a way to live life on life's terms."

A person is not weak because she cannot stop using, and must be told so. Sobriety is not easy because of the physiological, as well as the psychological, factors involved. The same holds true of mental illness. Stop the stigma and labelling. Without the right knowledge and support, how can the victim understand the illness, let alone the public in general? Recognizing the traumatic event that so changed the individual is a challenge. Accepting the change in oneself, the loss of who you were, is an enormous challenge. "How do I recover? I don't know how," is what I experienced and continue to hear in people searching for a better life than the existence they now experience.

(2) The same recovery philosophy needs to be promoted in the medical health field. "You know" is not an answer, neither is standardized delivery of information. There is little of "commonly understood" or that dreaded word "normal" in the recovery process. I had suppressed emotions for so long that they were unfamiliar when they started to come through; I remember how long it took to react to those emotions. To be told that my reaction was normal invalidated all the work I had done to get to that stage of recovery. I believe that the future of a more successful recovery lies with educational strengths-based groups that augment the standardized care that is dominant in our health system.

(3) Be mindful of the importance of affordable housing with supports in place for those with mental health and addiction issues. Those with mental health and addictions need affordable housing, and there is little available. In Toronto, the waiting list is seven years long or more. Without support, many who are more seriously ill are doomed to a life of loneliness and isolation.

(4) Be mindful of the importance of food, clothing and transportation costs, as well as shelter if affordable housing is unavailable. The supplementary income barely covers the cost of food, let alone clothing and transportation costs, if there is no affordable housing. Some form of subsidy should be made available to those requiring assistance covering the costs of their housing needs. Transportation costs in smaller communities can be as much as \$15 per trip for a medical visit. If you had

to choose between eating for the next day or two or seeing the doctor for ongoing treatment, what would you choose? Going hungry for even a day may make the medications being used less effective.

(5) Equality of care is a principle of the Ministry of Health; why is this not the same with Ontario Works and the Ontario disability support program? Why are people with addiction problems discriminated against? On the one hand, they are considered worthy because they are ill and are helped by the Ministry of Health to recover, but on the other hand, they are not worthy of government assistance through Ontario Works because they have a specific illness: addiction. What's more, Ontario Works punishes not only the person with addiction but his or her family as well. Even if the spouse receives assistance for the rest of the family, what happens if the rejected person is still in the picture? Are they not fed and sheltered by that family to the detriment of the whole? How does less food affect the mental and physical health of the children present?

Why is the ministry drug plan initiative not honoured by Ontario Works? Under ODSP, recent recipients continue being covered under the ministry drug plan, if their employer does not have one, for a full year. Why not longer? Under Ontario Works, you get any type of job and there is no such bridging coverage. Why not?

Without proper food, prescription drugs and supports, recovery becomes almost unattainable for those with mental health and addiction illnesses. Poverty and homelessness must be addressed now.

Consumer/survivor initiatives, CSI: I understand why the professionals don't give us the answer, why each individual in recovery has to find what works for himself or herself, but can we not help them find their individual answer? After all, recovery is discovery, and even more so, self-discovery is recovery. The healing might be easier if recovery information and possible solutions were presented in such a way that the individual could pick and choose his or her own personal fit, as I did; in my case, after years of searching for such options.

Financial investment needs to be made in the consumer/survivor initiatives such as TEACH. Groups are cost-effective. They bring together people who have, in the past, isolated themselves through ignorance, resulting in lack of self-worth. No more isolation, no more shame, no more need for excuses for being the person one is. Furthermore, I believe that a recovery plan supported by the Ministry of Health would pay for itself in the long run by helping people take responsibility for their own lives.

There are CSI agencies out there that are trying their hardest to reach people who are trying to help themselves. These agencies that believe in the strengths approach to recovery are pioneering client-centered educational skills programs that empower and enable people to begin taking a stand and taking responsibility for their own lives, in spite of a paucity of funds.

I find the inconsistency of funding by the ministry to various LHIN areas is inexcusable. For example, LHIN 6 is the least funded of the LHINs of the consumer/survivor

initiatives. An agency providing CSI services in Halton, with three times the population base of the Thunder Bay district, receives only \$129,000 per year, in comparison to \$619,000 for the Thunder Bay CSI. Where is the equality of service in that? How can such a travesty be justified by this ministry?

Last Tuesday, this fourth-year placement student started facilitating a recovery group, the beginning, if future funding allows, of a series of continuing, ongoing recovery groups. This program was developed after it became evident that one community had nothing to offer those who were in most need of developing a sense of self-worth. One participant spoke about the difficulty in seeing her psychiatrist, the months between visits because the doctor is so fully booked, the short time allocated to discuss her health concerns and receive a renewal of prescription for medications, and little or no time to deal with recovery. Her voice trembled as she said, "Thank God for TEACH and your support. I don't know what I would have done, what would have happened to me if you were not here." A moment of *déjà vu* on my part; is it any wonder that I too believe that the future for a more successful recovery lies with educational groups that supplement the standardized information that is rampant in our health system?

1720

A success story at TEACH is of a person who was agoraphobic and had lived in almost total seclusion for five years. After a year or so of support from Support and Housing Halton, this person found the courage to attend a recovery group, then a self-esteem group. Presently, this person is looking forward to the facilitator training group with the hope co-facilitating a recovery group in the near future. That is what the future can hold for someone attending these strength-based educational groups.

Ladies and gentlemen, I speak from my heart as a caregiver of a family member with mental illness. I speak about what I have experienced as a beneficiary of the health care system. I speak about what I've seen and heard as a placement practitioner of support services and what I have been taught as a student of family and community social services. That is also why I am here to advocate for hope, to give those with mental health and addiction illnesses hope. Help them more generously with their food, prescription drug, transportation and shelter needs. Give them the chance to gain the knowledge they need to learn how to help themselves. Present them with the choices to assist in their own recovery. It will pay off in the long term.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for your presentation. You have left time for at least a couple of questions. Anybody from this side? Christine, do you have a question?

Mrs. Christine Elliott: Thank you very much for your presentation. You have raised a lot of things that give us serious food for thought.

I'm particularly interested in the groups that you're speaking of. We've heard a lot about the importance of peer support. You're indicating very clearly that it's not

to supplement what you normally get in life skills training and that sort of thing. Could you tell us a little bit more about how you get the groups together, how they work, if they are ongoing, and what kind of physical needs and monetary needs you need in order to be able to successfully work in the groups?

Ms. Ewa Zakrzewska: That's a good question because at this point it's just beginning and there are very little funds. I'm a placement student at TEACH. Their funding for three people and rent is \$129,000 a year. Because I am there and I'm not being paid, they were able to put on two more recovery groups. I have facilitated in the past, but it's an ongoing process because the strengths approach is relatively new. What we do is advertise in the North Halton Mental Health Clinic, which is the area where I was working my groups, but we also have support groups in Oakville and Burlington. Acton is very poorly represented in the mental health support field.

When I started school, I spoke with my future field supervisor and she said she was appalled by what was happening. So that weekend I put together a package, because I had been researching recovery groups, and by Monday we had a plan for a six-week recovery group for those who had never been given an opportunity to be educated. These are for those less able to keep their attention. Over an hour period, they can learn one piece at a time. It has never been done. From what I've heard from outside of Acton, when I've mentioned it, as an example, to an emergency care nurse in Toronto, she said that it has been a long time coming. I personally see that as a wave of the future, a second tier for those who have been considered in the past less able to learn. They've never been given an opportunity to learn, and they're coming—as I said, on Monday morning, I presented this to my field supervisor; by Monday afternoon it was posted in north Halton, and by Monday evening I already had six people. There are 14 people in that Recovery 101, which is what it's called. This time around, we're doing bullying and assertiveness; in the next six weeks, hopefully, we'll be able to do a wellness kit, slow and steady progression, with the hope that they will eventually join the bigger recovery groups. But TEACH only has three major groups going. We lack the resources for putting on more groups. We have the people; we don't have the space.

Mrs. Christine Elliott: Would you be able to share that outline with us, that you've developed for the modules for the group that you're leading?

Ms. Ewa Zakrzewska: At this point in time? My assignment this year, as placement, was to have a skeletal recovery group where the components would be added as needed. With Recovery 101, the six-week program would be what would be in a two-hour session, for a 12-week program. So Recovery 101 would contain a lot of Recovery 1s Discovery, which is the other recovery group that goes into anger and anxiety and self-esteem issues—so these are all offshoots based on the same recovery core.

Mrs. Christine Elliott: Thank you very much.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today, and thank you for your presentation.

ONTARIO COALITION OF MENTAL HEALTH PROFESSIONALS

The Chair (Mr. Kevin Daniel Flynn): Our next presenter today is the Ontario Coalition of Mental Health Professionals. We've got Rod Cohen and Bob Bond joining us. If you'd like to make yourselves comfortable, I think we've got clean glasses up there; there's some water.

Like everybody else who's appeared before us, you get 15 minutes. You can use that any way you see fit. If there's any time at the end, we'll do what we just did and we'll split that time. It's all yours.

Mr. Rod Cohen: Thank you very much. That's a hard act to follow. My name is Rod Cohen. I'm the chair of the Ontario Coalition of Mental Health Professionals and I'm also the past president of the Ontario Society of Psychotherapists, which is the organization that I represent within the coalition.

Mr. Bob Bond: I'm Bob Bond. I'm the chair of the advocacy aspect of the coalition. You may remember seeing me before, because I presented in June for the Canadian Association for Pastoral Practice and Education, which is the group that I represent on the coalition.

Mr. Rod Cohen: I certainly appreciate the incredible volume, intensity and breadth of information and passionate presentations that you've been hearing over the past couple of months as you've been travelling around with the select committee, so I just really want to focus and make a few points. To begin with, I'd like to introduce the coalition to you.

The Ontario Coalition of Mental Health Professionals is an umbrella organization whose members are professional associations in the field of mental health. Founded in 2002 and officially convened in 2004, the coalition is an organization of non-statutory, self-regulated, like-minded partners dedicated to the recognition of the psychotherapy and counselling professions in Ontario. There are 13 member associations in the coalition, representing psychotherapists; counsellors; marriage and family therapists; art, music and child therapists and analysts; and spiritual therapists and chaplains.

The coalition was specifically formed to address the issue of the incoming regulation of psychotherapy and counselling in Ontario. It strives to understand the needs of the diverse community of its members in Ontario and aspires to be inclusive in its membership and a strong voice for the promotion of psychotherapy and counselling in Ontario. Our goals include promoting the development of policies and practices for the provision of accessible, competent and accountable psychotherapy and counselling services throughout the human life span, in a manner sensitive to the pluralistic nature of Ontario's society; to seek government regulation of non-statutory,

self-regulating mental health professionals as indispensable members of the health care system in Ontario; and to research awareness of the issues and their implications among professionals, government and other stakeholders.

We are pleased that the Legislature is taking a comprehensive approach to reviewing how the mental health of Ontario's population can be improved. Improving a society's mental health is about more than simply expanding access to Ministry of Health and Long-Term Care funded services. It is important for the committee to hear from those across the care spectrum who can identify opportunities for reducing gaps in care. As mentioned earlier, our coalition represents a broad range of therapeutic modalities in a vast variety of settings.

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As one example, in my own professional role I am the founder, executive director and lead therapist of a non-profit, community-based therapy centre for high-risk youth and families in Toronto called Blake Boulton Youth Outreach Service. Our mandate is to make accessible, intensive and long-term psychotherapy and counselling to a most vulnerable population who would otherwise be unable to access and afford it. Every day we receive referrals from traditional government-regulated youth and family treatment centres such as hospitals, shelters and child welfare agencies. They send their clients to us for a number of reasons. They lack the skill and expertise to work effectively with this very difficult clientele, they admire our model of long-term treatment and do not have enough staff to handle the demands upon their services, and therefore reach out to community agencies. This, I believe, highlights the importance of expanding government-assisted psychotherapeutic services especially to those who are most vulnerable.

Mr. Bob Bond: Within our current system, access to psychotherapy has characteristically been limited to either people who can afford to purchase it; people within their workplace employment assistance programs that happen to cover it; or people whose extended health coverage, under an extremely liberal and generous third party agreement, allows them to access it. What we celebrate and hope is that the establishment of the College of Psychotherapists and Registered Mental Health Therapists can broaden systemic access considerably and, with that access, shorten wait times in mental health and addictions.

Mr. Rod Cohen: There's the potential for improving the outcomes in Ontario by better leveraging the full diversity of expertise that is available now in the province. For a mental health strategy to succeed, it's important to recognize that not all people want to receive or benefit from care within a traditional medical model. Our members make an essential contribution to the overall care mix of mental health services available in our province. Again I refer to my own personal example. My agency alone last year met with over 225 clients, individual and family, from 31 different cultural ethnicities that were referred to us by 35 different sources such as

courts, hospitals, schools, police, traditional treatment centres and private practitioners. A diversity of practice models both complements and takes pressure off the OHIP system.

Mr. Bob Bond: For lack of accessing psychotherapy, many people with addiction and/or mental health needs currently cycle through our emergency room and hospitals, our courts and prisons without ever getting to, let alone actually addressing, their underlying stuckness, hurt, injury, loss, upset, trauma, anxiety or whatever other issues. This ends up costing huge amounts of money warehousing people and treating them in systems and in modalities that don't and cannot work instead of spending appropriate amounts to heal people and improve qualities of life.

Mr. Rod Cohen: This government's action to regulate the practice of psychotherapy through the Psychotherapy Act of 2007 was welcomed by our coalition, but we are now keen to see this legislation implemented. We strongly urge the government at this point to move quickly to bring the college of psychotherapists and registered mental health professionals to life. We know that the registrar is in place and we are in regular communication with her. We know that the transitional council has been selected and that the members are just waiting to start their work. We look forward to this very exciting phase of our profession to get underway.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much. You've left quite a bit of time for questions. Let's start with Christine. There's probably about two minutes each.

Mrs. Christine Elliott: Thank you for your presentation. We certainly have heard a lot in the course of the hearings about people who are being inappropriately caught up in our criminal justice system, for example. I'm wondering if you could give us some examples of how, if your role were expanded and more available, that could work in getting people out of that system or not getting into it in the first place.

Mr. Rod Cohen: Into the—

Mrs. Christine Elliott: —criminal justice system.

Mr. Bob Bond: One of the areas where that is possible has been referred to today: increasing the amount of psychotherapeutic resources available within primary health care settings like family health teams and community health centres. That immediately comes to mind, but anyplace where psychotherapy can be inserted alongside and be supportive of primary health is a boon.

Did you want to—

Mr. Rod Cohen: I just would add to that, Christine, that it's the kind of circumstance that I personally deal with on a regular basis. On any given day I will get a call from the court system, whether it be duty counsel or a mental health worker, asking if there are mental health services, psychotherapeutic services, available for people who are dealing with issues and are in the court system, looking for resources which would be far more effective and less costly than incarcerating people.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Rod. France?

M^{me} France Gélinas: I think you were here when the presenter was saying that putting psychotherapists in family health teams and certainly community health centres is a good way—I'm aware that quite a few community health centres offer mental health services; I'm not aware that very many family health teams do. There are 150 family health teams in Ontario. Would you know how many, if any, have psychotherapists on staff?

Mr. Bob Bond: I don't have statistics, but I know an example of one in Hamilton that does. They not only have some psychotherapy, but it comes in the form of several different kinds of practitioners. But I don't have statistics; I'm sorry.

M^{me} France Gélinas: That's okay. Thank you.

Mr. Rod Cohen: I'm also not aware of statistics. With regard to an example, I work in the lower east end of downtown Toronto, at the South Riverdale Community Health Centre. They have a family service team and they have social workers on staff providing psychotherapeutic services, who then refer out into community organizations like mine, for instance, because they have such a limited amount of time and resources. So it's emphasizing the importance of having greater accessibility, more than band-aids.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Rod. Questions from this side? Bas?

Mr. Bas Balkissoon: I wonder if you could just help us out, based on the previous presenter, and educate us on how one becomes a psychotherapist and what the prerequisites are.

Mr. Rod Cohen: One of the interesting things about psychotherapy is that it's, as I'm sure you're well aware, not a singularly identified profession or skill. The organization, for instance, that I'm involved in, and that Bob is as well—to be a psychotherapist requires a combination of extensive academic theoretical training, a very long period of clinically supervised work with clients and patients, as well as the mandatorily having performed your own or been involved in your own psychotherapy to understand yourself and the process.

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As we've been saying, it is a non-statutory, self-regulated field at this point. The self-regulated bodies that are in the coalition have a pretty much standardized definition that requires extensive academic training and practical clinical training, which really looks at the importance of core competency of skill in combination with academic training.

Mr. Bas Balkissoon: What would be the prerequisite to get into the program? Do you have to be a general practitioner—

Mr. Bob Bond: Do you mean academically? Academically, across our coalition folks are schooled at a master's level, and then clinically there are between 600 and 1,500 hours, depending on whether you're an art therapist, a music therapist, a child therapist—there's that

long set of hours of supervised clinical practice, to discover one's trade.

As Rod mentioned, there is a track of critical self-awareness and practice. In some organizations, that is through doing one's own therapy, and in some it's through other self-reflective means, as one trains.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Bob. Unfortunately your time is up, so will you be really brief?

Mr. Bob Bond: Very brief. One of the exciting things about the formation of the college will be, hopefully, a standardized level of practice involved in becoming a psychotherapist.

The Chair (Mr. Kevin Daniel Flynn): Thank you, gentlemen. Thank you both for coming today.

Mr. Rod Cohen: We appreciate it. Thank you very much.

ONTARIO SOCIETY OF PSYCHOTHERAPISTS

The Chair (Mr. Kevin Daniel Flynn): Staying on the same theme, we've got the Ontario Society of Psychotherapists coming forward. We've got David Schatzky and a mystery guest, who I'm sure you will introduce, David.

Mr. David Schatzky: I will introduce myself. I'm here for the organization.

The Chair (Mr. Kevin Daniel Flynn): Like everybody else who is appearing before us, you have 15 minutes. You can use that any way you see fit. If there's any time at the end, we'll do what we just did and see if we can't split it evenly amongst the three parties.

Mrs. Liz Sandals: Just a point of order, Mr. Chair, to explain to our guests that it's entirely possible that that bell is going to start to ring while you're talking. We're all going to get up and walk out and go and vote, but we'll come back.

Mr. David Schatzky: I won't take it personally. I've had enough therapy not to. Thank you.

Laughter.

The Chair (Mr. Kevin Daniel Flynn): We're all yours.

Mr. David Schatzky: My name is David Schatzky, and I represent the Ontario Society of Psychotherapists. I'm a past president of the OSP and a co-author of its standards of practice. I've been in private practice myself for about 15 years. Of course, you've just heard from Rod Cohen, who, by coincidence, is a clinical member of the OSP, my professional association.

I had written down that there's no way you would know that as part of our training, both Rod and I were required to see a psychotherapist for many hours ourselves, but in answer to one of your questions, he just revealed that. All members of the OSP have that as a very important prerequisite to getting into practice.

Having been in therapy ourselves, we appreciate not only what it feels like to be a psychotherapy client, but we also are much more aware of our own biases, patterns

of behaviour and the nooks and crannies in our own character that could get in the way of providing safe and effective treatment for our clients.

To be very personal for a moment, I first saw a psychotherapist when I was 15 years old, and I've used the services of psychotherapists on and off ever since. For example, even a few years ago my life felt very dark indeed for a while. A very important relationship came to an end. I was having difficulty letting go of it, and I was causing problems for myself and for others.

One day I spent a whole session with my therapist, complaining and whining and unburdening myself of some very, very deep and troubling thoughts I had about life and the problems I thought I was facing. I went on and on. My psychotherapist listened intently to my very negative rant, and with less than a minute to go until the end of the session, I paused to take a breath, and very quietly he said, "Well, that's one way to look at it."

Well, I burst out laughing, because with that one comment, he changed my perspective, and I was able to get through the next week. He didn't send me for tests. He didn't criticize my bad behaviour. He didn't tell me to change my diet. He didn't prescribe antidepressants. He simply listened, and what he said stayed with me, so that even now, whenever I feel discouraged, those words come back to me and it helps me—one part of the things that help me to carry on. That's just one tiny example of what therapists do and what can happen in a therapist's office.

Well, the OSP itself is a professional association of 300 psychotherapists. We provide mental health services to 15,000 Ontarians a year, many of whom find their way back to living a full life, without costly medication, without using hospital facilities and without other expensive medical interventions.

From the outset, OSP put into effect rigorous entrance requirements for our members: a master's degree or equivalent, specific training in psychotherapy theory and techniques, supervised clinical practice for hundreds of hours, and as you've heard, personal psychotherapy. We created a standards of practice; we adopted a code of ethics and put into place compulsory continuing education requirements. Over the last decade, OSP has enthusiastically, even passionately, participated in the process leading to the establishment of the College of Psychotherapists, and we did all this voluntarily because we're committed not only to our clients, but also to our profession.

You probably remember the old country doctor before OHIP. Well, we like to think of ourselves as being a bit like them: connected to the people who depend on us, but without the security of guaranteed payment for ourselves. Most OSP members work independently, mainly in our own private practices. Third party insurance doesn't pay for our services, but we're very much in demand. Perhaps that's because we pay very close attention to every word our clients say, and we build a relationship with them of trust and understanding.

It's that relationship which has proven to be therapeutic to people who are struggling with the complexities

of the human condition. They may be facing difficulties like intense anxiety; challenges in maintaining relationships; impulsivity which gets them into trouble at home, on the job or with the law. We help people with undermining feelings of inadequacy, with profound disappointment, loss or betrayal. We work with their anger and their rage. We help them cope when they feel overwhelmed by the complexity of the world or completely alienated from society. All these aspects of being human can be so paralyzing that some people barely function or constantly fail to meet their own goals. Some are very self-destructive or seriously disrupt the lives of their friends, family, co-workers or even their own employees.

That's where the therapeutic relationship with a psychotherapist comes in. We facilitate a process that helps our clients take care of themselves, get on with life, with their work, with their relationships.

At this point, you may well be thinking, "So what? Why are you here? What does the Ontario Society of Psychotherapists have to offer this committee?" Well, we know that you want to make sure that every one of your constituents gets the kind of mental health treatment they need, when they need it, for as long as they need it. That treatment should be with a practitioner they want to work with and who can help them effectively, a professional who can and will refer them, if necessary, to the more specialized services of addiction, psychiatry or medicine, and someone who is willing to work collaboratively with those specialists.

From your perspective, it would probably be even better if our services were not paid for out of the provincial treasury. Of course, if they're not paid for by the taxpayer, then they need to be at a cost the consumer can afford, and that's who we are and that's what we provide. Given your mandate to ensure that all citizens get better access to mental health services, the OSP would like to suggest that psychotherapists be considered among the primary providers of mental health services in Ontario—the general practitioners of mental health, as it were.

The role that psychotherapists play in the provision of mental health services in Ontario is often unacknowledged or misunderstood, but it's not inconsequential. Self-regulating psychotherapists in private practice have been meeting vital mental health needs for thousands of Ontarians for more than three decades. We are accessible in urgent circumstances and are available in centres without hospitals or other health care services. In many cases, we're the only provider who can meet the client's need for privacy and cultural sensitivity. Where social stigma may prevent people from seeking help, our non-medical, non-psychiatric orientation allows people to ask for help or seek treatment before it reaches crisis proportions. In other words, they don't have to feel as if they're sick or crazy to come to us.

Psychotherapy is both therapeutically effective and cost-effective. The College of Psychotherapists, which is about to burst upon the scene, creates a vehicle to bring

several thousand private-practice psychotherapists into the web of inter-professional collaboration to meet the mental health needs of Ontario. And you're absolutely aware that most people don't know where to turn for mental health services, and, as someone mentioned earlier today, they're certainly confused about the names and the titles and who is who.

You know that access to an MD/GP is a real issue for many rural citizens, and finding a private-practice GP who is taking on new patients can be difficult even in the best-served urban areas. So people are very puzzled about who can give them the help they need and where to find that help.

For that reason, a publicly funded educational and advertising campaign which lets Ontarians know about psychotherapists, GPs and local agencies would be extremely useful. It would point them in the right direction. If they're in a crisis or if they want to prevent their distress from becoming a crisis, far better to seek help and find it than to commit suicide. A publicly funded campaign which points the way to mental health services that Ontarians need would be, at the least, very helpful and, at best, life-saving. Well, that's at least one way to look at it.

The Chair (Mr. Kevin Daniel Flynn): Thank you, David. We've got about five minutes left. I think the bells may start ringing very shortly. I just don't know—how long is this vote?

Mrs. Liz Sandals: I think it's 10 minutes.

The Chair (Mr. Kevin Daniel Flynn): If it's a 10-minute, then we can question you for four. So let's start with Christine.

Mrs. Christine Elliott: Lots to think about here. The idea of having access so that people could come to almost normalize the seeking of therapy before it reaches crisis proportions—it seems to me that that would be very valuable and would save the system money over the longer term. Is that more or less what you're—

Mr. David Schatzky: That's one of the things that I've been trying to convey, for sure, yes. Many of the people we see in fact have that point of view. They know that there's something troubling them, there's something to deal with, and we're their first line of defence.

Mrs. Christine Elliott: And I guess just having it available through the system, whether it's part of a family health team or whatever, helps deal with the stigma aspect of it as well, because it's something that's available for everybody in that they can avail themselves of it, if needed.

Mr. David Schatzky: Absolutely.

The Chair (Mr. Kevin Daniel Flynn): France?

M^{me} France Gélinas: I truly enjoyed your presentation. You're a very good presenter, so it made it very lively and interesting and made it very clear, as well. Your message is clear; your focus is on improving access. One huge barrier to access is the ability to pay. So your points are clear and well taken and I thank you.

Mr. David Schatzky: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Anybody from the government side? Helena?

Ms. Helena Jaczek: Yes. Thank you for the presentation. I'm just wondering, if you do have a client who you feel is suicidal or perhaps psychotic and in need of medication, how do you refer back into the medical side of things?

Mr. David Schatzky: Very simply and directly. We talk about why it's maybe necessary and I try to facilitate putting them in touch with the right person, and sometimes I might even—I've even had occasion to make the call myself while they're in my office.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today, David. It was a very good presentation.

Mr. David Schatzky: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Is Iris in the audience? You're going to feel a bit left out because we're going to leave and then we're going to come back. If you don't mind waiting, we're going to vote in seven minutes and then we'll be back here in about two or three minutes. So if you don't mind waiting 10 minutes—

Ms. Iris Kairow: That's fine. Just make sure you have your package read by the time you return so that I can quiz you on your homework.

The Chair (Mr. Kevin Daniel Flynn): Hey, we've got nothing else to do. As long as you're not offended, we're going to leave you. Thank you.

The committee recessed from 1752 to 1807.

IRIS KAIROW

The Chair (Mr. Kevin Daniel Flynn): Our next presenter is Iris Kairow. Is that right? You've got 15 minutes like everybody else, and you can use that any way you see fit.

Ms. Iris Kairow: Thank you. Our story begins with a carefree child, designated as gifted, with enrichment at advanced schools, successful at chess, track, soccer teams.

Grade 9 was nearly fatal when a 20-kilometre joyride crashed the teenagers into a pillar. Thank goodness for a smart judge who ordered a psychiatric assessment, but there is no test for schizophrenia. Many tools are based on what a patient says during an interview. When we walked out with a clean bill of health, I knew he had lied to these doctors, too.

Then he phoned me from Hamilton saying he was tired from roller-skating on the QEW from Toronto in two hours. Our child was attacked by the Crips gang in the Kingsway, so he believes. One neighbour witnessed teenagers dancing on my steep roof—waited three weeks to point out the insurance liability might become a financial issue for me, so I hired a housekeeper. But our son likes to cook in the middle of the night. He caused two accidental fires, totalling \$12,000—more sleeping medication for us, and we all wished he could live in a group home.

Truth is, our child slept in High Park as one of Toronto's 7,000 homeless. Our child gave out beatings and suffered beatings in seven shelters. Changing door

locks did not keep our younger siblings safe. Our child repeatedly used surprise by breaking into his own home via the dog door flap. With each stolen bicycle I brought to the police, I explained that he took instructions from specific younger boys who were ringleaders.

I helped the crown prosecute a break and enter just to take beer, but they happened to find an antique gun. "Mommy, what is bail money and why don't you just give it?" "Because, sweetie, the social worker advised us to leave him inside that place." After names were read out in court, I thanked a neighbour for supplying a witness statement, but they denied it. Another neighbour came onto my porch to tell me, "I think your family had better move off this street."

If schools had spotted him for an early intervention program, symptoms would have been less severe; his two younger siblings less shamed; fewer nightmares; I'd have spent more time, more hours, with my younger two children rather than dragging myself to seminars on parenting and substance abuse.

As it unravelled, from probation office, CTYS, George Hull, Breakaway, psychiatrist, two social workers that I arranged privately, no one told us that marijuana triples the risk of schizophrenia. I had no idea our son was losing 20% of his brain tissue. I should have been less strict about alcohol and more about smoking?

It was not until much later, after our son was called names—some of the 270 phrases for insanity—after his fourth high school, after living at Eva's Phoenix, that anyone mentioned the word "schizophrenia."

When his teacher mentioned that he was in hospital, classmates relayed several instances of swallowing metal screws. This will become a reportable event after the select committee's work is finished.

Our son's first two medicines were not very effective. He continued to chew wood off his bedpost and swallow pennies. When he explained his perpetual emotion waterwheel, the psychiatrist shrugged it off. If I had only known that schizophrenia patients lose cognitive function with each breakdown—dropping from IQ 100 to 65—and that they could recover some cognitive functions with brain tissue growth, called plasticity, with early medicine.

Let's recall a single fact that car rental companies enforce: A healthy person is not considered responsible until 25 years of age. When our son announced his AIDS cure with mini robots, the psychiatrist suggested university admission. Doctors recommended adjusting amounts or types of pills, but a 17-year-old enjoys prolonging debate. It's a waste to plead this decision with a three-person legal board.

Our son never refused to swallow his medicine for any health professional. Twice, CAMH psychiatrists took lawyers to the Consent and Capacity Board for the same purpose: to switch from one pill to another pill. They had to take several hours away from other patients to state that my son was incapable of appreciating the reasonably foreseeable consequences of a decision. When alternatives have not yet been experienced, no patient can foresee around a corner.

CAMH's social worker staff expedited ODSP approval. That made it impossible to persuade a paranoid person that living with less pocket money in a group situation would be more therapeutic for him. If our eldest child had been able to live in a group home, then he would not have kicked his little brother in the head. Unfortunately, his brother's concussion cost public expense two hospital visits. Waking up at the YMCA, he ran naked many blocks before police apprehended him. Annually, Toronto police log 10,000 responses for emotionally disturbed persons, six hours a call at \$36 per police hour. Back in the ER, physical restraints at all four points were required. This was worse than visiting in the jails. In the future, we can reduce the 19,000 ER visits made by schizophrenia patients.

In 2002, had we the fortune to live in New York, New Brunswick or British Columbia, access to standard treatment would not have been an argument. I would not have lost my argument with ER psychiatrists that setting fire to his own hair at midnight on December 24 was insufficient legal grounds. That doctor discharged my son on December 26. Seven years of medical training, and the doctor is talking legal matters. Ontario law is quite clear: A danger must be evident. Perhaps 72 hours' time allows substances to wear off; paranoia actually worsens.

Some mental illnesses do not cause incapacity, but persistent psychosis and paranoid schizophrenia are defined by irrational thought patterns, intrusive thoughts, disjointed ideas, random delusions and lack of judgment. Paranoia prevents patients from selecting a choice or trusting any advice. It's a no-brainer: These few patients should not decide their own health treatment.

I know this committee can set a clear destination on how matters should be. Like laws about jaywalking, bike helmets, school truancy, idling cars and clearing our snow, laws set out the ideal. Please leave the enforcement for specific situations. Please leave the wranglings of implementation to those who do practise medicine and law. His father and I spent hours reviewing how we could get publicity or legal action to remedy how our son was being denied appropriate medicine.

The same day that my son tells me a row of elevators is actually a computer hard drive, his psychiatrist asks his permission for switching to a third medicine. I ask this committee to revise regulations so that the legal right to refuse standard schizophrenia treatment only be presented to youth after they have completed eight months of that medicine. Where schizophrenia or suicide issues are confirmed, do not seek permission from youth under age 20. Where degenerative brain disease and other severe mental diagnoses are being treated, suggest to medical practice guidelines that they treat youth as minor children by involving the next of kin—only for paranoia and schizophrenia. For patients with a confirmed diagnosis who are treatment-naïve, the legal right to refuse medicine should not be suggested as their own choice until they are over 25 years of age. Your existing rules permit all patients to refuse standard pills for their mental disorder, which would only make sense for adult patients

who have maturity or who have eight months of experience on medicine on which they could base their judgement, or if the history of paranoia and schizophrenia is not yet confirmed. I'm talking only about standard pills, not injections or ECT or new trials, and I mean only for the mental disorder, not for other aspects of their health.

1820

Today I'll list 10 actions, each with zero cost. Elected members can start these immediately:

Talk with your local police to estimate how much money is devoted to respond, restrain and escort EDP, emotionally disturbed persons.

Track mental illness as a contributing factor to crime, major or minor, along with violence against women, hate crimes. These are tracked, and the statistics are published.

This very week, watch five videos: Jesse Bigelow in *FearLess*, *A Beautiful Mind*, *The Soloist*, *Fight Club*, *Benny and Joon*.

For the next two months, wear your watch on the opposite wrist, don't wash your hair, to see how this feels.

In your riding newsletter, print a poem or anecdote about a mental disorder. Award a certificate to a constituent who writes a short essay.

Tell your developers, landlords, real estate professionals, clubs and charities there is a high demand for basic accommodation. Renters with severe mental illness do guarantee monthly payments through electronic transfer of ODSP funds, and it is illegal to discriminate against disabled people.

Ensure children's books about mental health are included with those that are already being published and purchased by schools and libraries. Buy some for your office waiting rooms. I've suggested a list attached in your package.

Switch to ordering snacks from the Raging Spoon Catering Company and similar businesses that are listed in the back of your list of alternative businesses.

Stop on the sidewalk to talk to people with mental disorders so you can discuss how stereotypes, prejudice and discrimination help stigma persist.

Ensure regulations are amended to encourage treatment so that Ontario law may keep pace with seven other provinces' mental health legislation.

And the number one way that you can start today with zero cost: Make severe mental disorders a priority by arranging the donation of your brain tissue for science.

The time is now for making it happen.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Iris. We've got a little bit of time left. Looking at my time here, you've left about a minute and a half. France, would you like to take that?

M^{me} France Gélinas: I want to thank you for bringing your story, and I think your top 10 ideas are all good.

You talked about early intervention. Do you see this as something that would be available in every school?

Ms. Iris Kairow: I live in the best country, in the best province, in the largest city with excellent schools. I

talked to the social worker, the guidance person, about the fact that my son is gifted, maybe a little mischievous. Nobody ever mentioned schizophrenia.

But please don't waste public money on advertising, because there has already been a lot of money wasted on anti-stigma advertising, and according to Canadian research that was done in Calgary, it was not effective.

The most effective thing, I think, would be more to increase our familiarity by a requirement for job placement as affirmative action. This increases the percentage that we meet every day—the mail person, the janitor—and then we understand better. Apparently, headlines and brochures and news stories don't really improve the problem of stigma.

Please don't rely on the police to be social workers. I have an MBA and in my day job, I work on the traumatic mental stress team of the Workplace Safety and Insurance Board. We have a lot of difficulties with suicidal police who are finding these youth suicides horrendous to cope with. They try to be macho and keep a stiff upper lip, but eventually—this is part of the iceberg, where there are hidden costs, a domino effect, and it really impacts a lot of other people when there are negative outcomes.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for your presentation.

Members of the committee, that was our last delegation of the day. I want to draw your attention to a few points: You have a memo before you from Elaine, the research officer. It looks like this. That's something you can perhaps think about in preparation for our meeting next Wednesday at 12 noon. It's a lunch meeting in committee room number 2. It's something to think about.

On November 20, for the meeting between us and the minister's advisory group, out of the nine of us, we've had seven people who have said that they will attend. There are two people who are unable to attend, but does the committee still want to go ahead? Seven out of nine is pretty good.

Mrs. Liz Sandals: Maria and I are just saying that public accounts I think will be meeting at 12 to 3 as well.

M^{me} France Gélina: Noon on Wednesday.

Interjection.

Mrs. Liz Sandals: That's now got another three of us.

The Chair (Mr. Kevin Daniel Flynn): No, this is November 20.

Mrs. Maria Van Bommel: No, no. We're talking about next Wednesday. You talked about noon Wednesday.

Interjection.

Mrs. Liz Sandals: Is it possible—oh no, because we're going 1 to 3.

Mrs. Maria Van Bommel: We've got a conflict.

The Chair (Mr. Kevin Daniel Flynn): From 1 till 3?

Mrs. Liz Sandals: How long were you thinking the meeting would be?

The Chair (Mr. Kevin Daniel Flynn): Well, it can be as long as you want. It's really informal. It's a chance for everyone to get together, but rather than rush it, I'd sooner not do it. You're not going to get it done in an hour, if that's what you're asking.

Mrs. Maria Van Bommel: I think we're supposed to start at noon next Wednesday.

Mrs. Liz Sandals: I was going to say, if I could ask—see if Norm would agree to leave it until 1—

Interjections.

The Chair (Mr. Kevin Daniel Flynn): How many other members can make it on that day? We've got to give this thing some priority.

Ms. Helena Jaczek: October 7 at noon.

The Chair (Mr. Kevin Daniel Flynn): Okay. Well, we're just going to have to go ahead unfortunately, unless public accounts wants to change its schedule.

M^{me} France Gélina: This is for the report writing?

The Chair (Mr. Kevin Daniel Flynn): Yes. I just don't want to leave it any longer if I can help it.

The other thing you could do, Liz, is, if for some reason it doesn't work out that you can attend, if you would read Elaine's memo and if you've got anything to provide in writing or even if a staff person could come on your behalf, that would work as well. Okay?

Thank you very much for attending.

The committee adjourned at 1825.

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Wednesday 7 October 2009

Journal des débats (Hansard)

Mercredi 7 octobre 2009

Select Committee on Mental Health and Addictions

**Mental Health
and Addictions Strategy**

Comité spécial de la santé mentale et des dépendances

**Stratégie sur la santé mentale et
les dépendances**

Chair: Kevin Daniel Flynn
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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

SELECT COMMITTEE ON
MENTAL HEALTH AND ADDICTIONSCOMITÉ SPÉCIAL DE LA SANTÉ
MENTALE ET DES DÉPENDANCES

Wednesday 7 October 2009

Mercredi 7 octobre 2009

*The committee met at 1601 in committee room 1.*MENTAL HEALTH
AND ADDICTIONS STRATEGY

SKY STARR

The Chair (Mr. Kevin Daniel Flynn): If we can call to order. Everybody's just getting settled here, but I'm going to ask Sky Starr, if you would come forward and get yourself nice and comfortable. There's some water, some clean glasses there for you, if you need them.

I'll just explain some of the rules for those in the audience as well. Every delegation gets 15 minutes. You can use that any way you see fit. It would be nice if you would leave some time around the end for some questions that some members may have, but that's entirely up to you. As the other members are just sitting down here, I'm going to turn it over to you. I'll let you know when there's about a minute left, just so you can summarize, if need be. The floor is all yours and thanks for coming today.

Rev. Sky Starr: Good afternoon. I'm very grateful for the opportunity to present this. I am a minister and a therapist. I work and live in the Jane and Finch community. My focus right now today is just to present some of the situations that are happening in Jane and Finch, as in the many other priority neighbourhoods. I'm just raising the awareness of grief and the support that grief needs within the community and that youth and family need in the community.

In one report, Gina Browne says, "The prevalence of mental health problems...occurring among younger cohorts, leads...to search for practical solutions to reduce the burden of suffering on children and their families, and the costs to society both immediate and long-term."

Most of the stuff that happens within the Jane and Finch community happens around loss and around violence. It affects the homes and the families. It affects individuals, churches, and it's everywhere. I'm very grateful that it's not only in the Jane and Finch community, but it's also in the other 13 priority neighbourhoods.

As part of the "eye on community," the lack of mental health supports for children and youth is very evident. Generations of people are not exposed to resources. The life trajectory remains alarming. Accessibility is minimal to nil for a population of over 100,000. There are

virtually no clinical services available to youth. Mental health issues are entrenched in youth, families and in the community. I just wanted to raise awareness on that.

There is much empirical data which presents that, which supports that. Part of that you will have in a binder that I provided for you. I wouldn't want to waste time going into it, but everything is in that blue folder that you've got in front of you.

The one thing that I'd like to stress on this is, it is important to decrease the stigma both in those with and without mental health illness, particularly in communities where we're expecting youth to grow up to be responsible adults, responsible people in the community. Most of the stuff that you see happening with youth is depression, anxiety disorders, insomnia, inability to cope, social disorders, decreased productivity, negative behaviour patterns, violence, grief, and the cycle just repeats itself. All of these things that are listed here that are associated with grief and loss should be on the mental health radar, and they are not.

A lot of youth suffer in silence and isolation. I would go to a school, for instance, and a teacher would be motioning me inside because a youth has broken down in the class because they're triggered by a word or something that is said during a lecture or during stuff that is happening in the classroom. A lot of the stuff that's happening to kids is overlooked, especially the youth. They're overlooked, misunderstood and misdiagnosed, and the cycle continues.

The negative outlook that we see within the community—marginalization, stigmatization and all of that—I'm sorry, I've got to go back a little bit here. Excuse me for a second—marginalization, stigmatized. They are isolated. There's degradation. There's a dismal future for them—unrealized dreams—and kids continue to go through the process of that without having the clinical mental health attention that they need.

A lot of the anger and frustration that is felt among youth is felt because some of the attention that they need is not there. They're frustrated and angry and it leads to different things like violence, death, grief and grief-related situations in the community.

Grief, as we know, is a natural part of growth and development, but a lot of people are not comfortable with grief, and so a lot of people stay away, tend to shy away from grief. There is virtually nothing except what we provide in the community. I contacted BFO and the

product that we extend is a mutual peer support model. That relates to the entire community grieving, because no one agency or even 10 agencies are able to provide the support that is necessary there. So the fears and phobias—and grief is not a yes or no process. At some point we are all going to go through that because every living thing dies and the connection to grief is connected to everybody. At the end of the day, whether we want to admit it or not, it is something that affects us and it's not just grief related to death but loss in general on any level.

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Grieving is like a natural process. It is something that we probably need to look at and pay attention to. The goals and challenges that I find working in the community, the preventive measures that we need to support youth, especially youth—I got a call this morning. I'm on the crisis team, and I got a call from the city that there was a stabbing again. There was a young man in the hospital who is in critical condition, and probably by the time I get back, I will hear that this person has died. They're going to need grief support for the family and the community again. This is something that is very prevalent, that is very there and needs to be attached to the mental health radar and it is not, because most of the things that the kids and youth are experiencing are all related to mental health.

Many recommendations have been given. The latest we have is the Alvin Curling report. We have reports like that coming from every direction, but they get shelved. They're just piled there; nothing is being done. I would like to implore you to really look at the situation, not just in the Jane and Finch area but also in the other 13 priority neighbourhoods. This is a serious epidemic that we have. I call it an epidemic because I believe the entire community is grieving.

I'd like to raise the awareness that there's a stigma attached to mental health. There's a stigma attached to grief. Within our communities, our youth are suffering. They cannot function properly at school. Grief is something that is entrenched in the children and youth and the family. It's a cycle, a spiral effect that continues to happen. I think we need some immediate attention to that, starting on a systemic level, starting with people realizing that grief and all the fallout from grief are attached to mental health.

As a therapist, when I go to a school, when I go to a group, everything that relates to mental health relates to grief: insomnia, restlessness, depression, social anxieties. All of these things are there. I really would like to impress on you that we need to implement something that is positive for the community, have the support system set in place so that we are able to service the community and the other 13 priority neighbourhoods that are experiencing grief.

Sam Houston said, "The benefits of education and of useful knowledge generally diffused to a community are essential to self-preservation." My sons are 16 and 17. I have two, and I would love to see them live to be maybe 21, but the consensus in the 13 priority neighbourhoods

is that you never know. Youth live in fear and the community is in fear, and we really need to have things set in place to support this.

I thank you for listening to me. Any questions?

The Chair (Mr. Kevin Daniel Flynn): Thank you, Sky. You've left quite a bit of time for questions; thank you for that. Each party has about two minutes, so let's start with either Christine or Sylvia.

Mrs. Christine Elliott: Thank you very much, Reverend Sky, for coming here today. I really do thank you for your presentation because we certainly are aware of the need for more mental health services for children and youth, but you've raised it in an entirely new context that, quite frankly, I hadn't thought of.

Rev. Sky Starr: I'm sure.

Mrs. Christine Elliott: I certainly do appreciate that. I want you to know that we are thinking across ministries, across boundaries. With respect to your recommendations, you have suggested that we should have a lead ministry. Could you give us some suggestions on maybe your top few things that you think would be the most beneficial things that we could put into place in a perfect world?

Rev. Sky Starr: First of all, my concentration is on youth because they are our future. For youth within the community, we only have Dellcrest, which is there, but the connection to the community is minimal to none. I'm not knocking their services, but I'm just saying that within the community, the level of service that the youth need is not there. When a shooting happens, for instance, I get calls. My phone is just going off the hook because I'm virtually the only therapist within the community who's providing grief services. Granted, I do understand that it's a very scary topic, a very painful topic and a lot of us don't want to go there, but we need to go there because it is happening. It is affecting our youth and it is in the community.

So my recommendation would be: First of all, we need to have clinical places and areas where youth can go, where they know that if they're in crisis—grief particularly is not something that you can say, "Today, I'm feeling this; tomorrow, I'm not feeling this." It's an ongoing process. People never get over grief, but they are triggered by different things. If there were something within the community where our youth know, "Okay, that's there. When I'm feeling like that, I know I can go there"—we don't have that.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Sky. We're going to move on to France.

M^{me} France Gélinas: Continuing with your train of thought, could you describe to me, "We can go there"? What would "there" look like? What would make it open to youth, who usually run away from anything that has to do with mental illness or mental health services because of many reasons? So, describe to me: What would "there" look like so that it is accessible to youth?

Rev. Sky Starr: A physical space, for instance; a safe space where they feel safe. A space that probably has a snoezelen room, a quiet space; a space where they can go

and just relax, unwind. A space where they know there's somebody there to listen to them, or even sit with them in the process that they're going through. A physical space, which we do not have right now.

The Chair (Mr. Kevin Daniel Flynn): Thank you, France. Any questions, Helena?

Ms. Helena Jaczek: Thank you very much for your presentation. I was wondering if you could just elaborate a little bit on your Out of Bounds grief support program. It looks like it's quite new.

Rev. Sky Starr: Yes, it is.

Ms. Helena Jaczek: Could you describe how the peer support works? Do you have any results in terms of outcomes, or is it too early?

Rev. Sky Starr: No, no. You've got some leaflets in there. If you would look through it, there are results in there.

The program started in 2007. I contacted BFO because I saw the need in the community and wanted to help. I felt it was insurmountable for me, so I contacted BFO. I arranged to set up some focus groups in the community. We had over 50 youth attend, and—the myth that we have about, “Men don't cry”—we had young men on the floor crying. For me, that was success. Probably you would think that people crying is not success, but for me it was an outlet to see that happen.

All of those youth wanted to have something in the community, a space or somebody they can go to for help, so Out of Bounds was started. I started Out of Bounds with community people: half youth, half adults. Right now, we have 16 people—eight youth, eight adults—and it is growing.

We have a training program going on right now that I am setting up. It's a 13-week program that just started last week and it will run until December, so that community people are trained in a peer-to-peer support model where a parent can relate to a parent, a youth to a youth and suchlike.

Ms. Helena Jaczek: Did you model it on any other existing programs?

Rev. Sky Starr: Modelled on BFO's existing program, Bereaved Families of Ontario, which has been in operation for 30 years. We are partnering with BFO for three years, and at the end of 2010, hopefully the community is sustained enough—and this could be a pilot program that can be extended to the other 13 priority neighbourhoods. That's my vision.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today. One question: Have I heard you on the radio before?

Rev. Sky Starr: Yes, you have.

The Chair (Mr. Kevin Daniel Flynn): I thought so. I thought I recognized you.

Rev. Sky Starr: Well, thank you.

The Chair (Mr. Kevin Daniel Flynn): I thought I heard you giving an interview over some event.

Rev. Sky Starr: Yes. I'm just talking about people listening to youth. They need to listen to the youth. If

you're asking for their opinion, you at least need to listen to them. Just don't totally disregard them.

The Chair (Mr. Kevin Daniel Flynn): Perfect. Thank you very much for coming today. I think you got your point across very clearly.

REGISTERED NURSES' ASSOCIATION OF ONTARIO

The Chair (Mr. Kevin Daniel Flynn): Our next speaker this morning is somebody everybody will know: Doris Grinspun. If you'd like to make yourself comfortable, Doris; there's some water and some glasses if you need them.

Thanks for coming on behalf of the RNAO. Like everybody else, you get 15 minutes, and you can use that any way you see fit.

Ms. Doris Grinspun: Thank you so much. I'm Doris Grinspun, the executive director of the Registered Nurses' Association of Ontario. We're the professional organization for registered nurses, who practise in all roles and sectors across this province. I'm very proud to be here today with my colleague Pat Nashef, president of RNAO's mental health expert group.

On behalf of Ontario's registered nurses, we would like to commend the Select Committee on Mental Health and Addictions for their work in addressing an issue that is vital for the health of individuals, families and communities. One in five people in Ontario has a mental health challenge at some point in their lives, and it is estimated that at least 60% of individuals diagnosed with mental health illnesses also suffer addictions.

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The committee has heard testimony from the Centre for Addiction and Mental Health that nearly 12% of the burden of disease is comprised of mental health and addictions, but Ontario consistently spends only 5% of the provincial health budget on mental health and addictions.

Our government's own report Every Door is the Right Door points out that, in total, including lost productivity, law enforcement, disability claims, drug costs, employee assistance claims and other factors, mental health and addictions costs Ontario at least \$39 billion per year. In fact, every dollar spent in mental health and addictions saves \$7 in health costs and \$30 in lost productivity and social costs. The importance of strategic investment in mental health and addictions services cannot be overestimated. We simply cannot afford not to invest in this area.

To be healthy and live in dignity, Ontarians need to have access to liveable incomes, safe and affordable housing, nutritious food to combat persistent hunger and food insecurity, work that pays a living wage, high-quality early learning and child care, and a system of client-centred health care and community supports. This health care, whether in hospitals or in the community, must be coordinated, seamless and accessible to all.

Access to these conditions that foster health, including health care, is a fundamental human right.

It is timely that it is today that we speak again to you about the connections between social determinants of health and good health as we welcome Minister Deb Matthews as our new Minister of Health and Long-Term Care, coming from her previous portfolio where we worked closely with her on tackling poverty in Ontario. We are also very honoured to learn that we are appearing before the committee today on the same day that Barbara Hall, chief commissioner of the Ontario Human Rights Commission, will be presenting to you.

As registered nurses, we urge our province to live up to article 25 of the Universal Declaration of Human Rights, which states: "Everyone has the right to a standard of living adequate for the health and well-being of" him or herself and his or her "family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his" or her "control."

Nurses say, "Let's start with the fundamentals if we are to seriously tackle mental health, addictions and overall wellness."

We urge the committee and the McGuinty government to step back, look at the immediate needs of people living with mental health challenges and remember they represent 20% of Ontarians, one in five—in fact, one in five of us in this room. We ask that you review Ontario's mental health and addictions system carefully in the context of the real needs of persons living with mental health challenges and lead with boldness.

We propose that you:

(1) Accelerate the progress of the government's poverty reduction strategy, released in December 2008.

(2) Move urgently with the transformation of the Ontario disability support program and Ontario Works so it alleviates rather than exacerbates poverty and human suffering and treats clients and staff with dignity.

(3) Withdraw the government's appeal of the Ontario Divisional Court ruling that found that, under the Human Rights Code, addictions could be considered when deciding whether an individual is disabled and eligible to access the Ontario disability support program.

(4) Prevent people from being forced to choose between paying for food or paying for shelter. Social assistance rates need to be significantly increased so that they reflect the actual cost of living. In the meantime, there should be a \$100-per-month healthy food supplement introduced to address the gap between dangerously low assistance rates and nutritional requirements. People should not need to choose.

(5) Fast-track the provincial housing plan, including: capital subsidies to build new affordable housing or renovate existing housing stock that is substandard; rent supplements to ensure affordable housing for low- and moderate-income households; and supportive community-based housing and services for those with physical, cognitive and/or mental health needs.

(6) Fund professional education in mental health and addictions screening, assessment, determination of early recognition and diagnosis, and immediate intervention across all professions as a basic entry-to-practice requirement. This will increase efficiency in health care and provide the opportunity to clearly address mental health and addictions stigma issues when these professionals are graduates. This can be accomplished by ensuring the development of specialized postgraduate education in mental health and addictions, and continuing education throughout that individual's career span.

(7) Improve access to high-quality primary care across the province. We are well on our path; we need to accelerate that.

(8) Develop a systematic and seamless mental health care system for all Ontarians, with sensitivity to cultural norms, delivered at the individual's preferred location, with special consideration for disadvantaged individuals such as those coming from aboriginal communities, older adults and elders tackling new and ongoing mental health and addictions challenges, people from racialized communities, people with disabilities, and children and youth requiring increased and enhanced mental health and addictions services. Several outstanding models of care exist already in the US, the UK and Australia; we don't need to reinvent them.

I will now ask my colleague to present to you.

Ms. Pat Nashef: Thank you and good afternoon. As many individuals and organizations—

The Chair (Mr. Kevin Daniel Flynn): Pat, if you could just introduce yourself for Hansard so they know that Doris's voice hasn't suddenly changed.

Ms. Pat Nashef: Good afternoon. My name is Pat Nashef. I'm the president of the mental health nursing interest group of the Registered Nurses' Association of Ontario.

The Chair (Mr. Kevin Daniel Flynn): Thank you.

Ms. Pat Nashef: As many individuals and organizations have already testified to this committee, it is imperative that people facing mental health and addictions challenges receive respectful, equitable, appropriate and seamless client-centred access to health and social services. We need to address stigma in perceptions, attitudes and actions, including funding that creates the conditions for people with mental health and addictions who experience isolation and neglect.

We need a coordinated, comprehensive approach to mental health and addictions so that there are opportunities for building resiliency throughout the life cycle through prevention, assessment, intervention, treatment and ongoing support that demonstrates our societal commitment to treasure every Ontarian.

I have had the privilege of working in psychiatric mental health nursing for more than 30 years. I know that this is a complex issue. People may not recognize that they have a problem, they may not know what kind of help is available, or they may know what exists but are unable to use the services because of barriers such as cost, language and transportation. They may have

difficulty finding what they need when there is a wide range of services and no single point of access. In some cases, the right services for their specific concerns may not be available nearby.

A radical shift in beliefs and paradigms about persons with mental illness and addictions is required, fostering an open dialogue and a systemic belief in recovery. People need to be able to access mental health and addictions prevention and treatment services through every door, but it is critical that this occurs well before the individual hits the criminal justice portal. Indeed, when persons with mental health challenges arrive at the criminal justice portal, it is highly likely that the Ontario mental health and addictions system has not met all of this person's mental health needs.

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For example, the deinstitutionalization of persons with longer-term mental illness commenced in the 1970s here in the province of Ontario and took place at about the same time as the devolution of housing from federal authorities to provincial authorities, and finally on to municipal governments. In fact, I personally had the professional experience of discharging two patients from the Queen Street Mental Health Centre in 1979 who had been full-time patients since 1924 and 1937, respectively. Regrettably, large numbers of people being deinstitutionalized were not accompanied by sufficient community supports, particularly affordable and supportive housing.

Homelessness, in relation to mental health, is an enormous issue, and the transition from hospital to community is complex. In a compelling research study conducted by Dr. Cheryl Forchuk, a member of RNAO, the mental health nursing interest group, and a noted nurse scholar in London, Ontario, studied individuals who had no prior history of homelessness, but were about to be discharged from psychiatric facilities and in-patient psychiatric units. They were divided into two groups: one that received the intervention and one that received the usual care. Those in the intervention group had help in contacting Ontario Works or the Ontario disability support program to fast-track the community start-up fees that assist with first and last month's rent at a new apartment, as well as help in finding an apartment from a housing advocate before discharge. This meant that they exited the hospital with a secure place to live, first and last month's rent paid and some money in hand to buy essentials, as well as ongoing access to mental health, financial and social supports.

In Dr. Forchuk's study, a strategy was created that involved a direct computer link from the psychiatric facility or unit to the Ontario Works and housing databases. Instead of taking one or two weeks, cheques were in hand the same day. Results were so dramatic that the study was stopped for ethical reasons. It was found that all seven people who received the intervention were still housed six months later, but shockingly, six out of

the seven who received the usual care were still homeless six months later. The seventh had joined the sex trade for the first time to avoid homelessness with her small child and, six months later, was still in the sex trade.

In the past year, only 10 people were discharged to homelessness in London, Ontario, compared to almost 200 in 2002. This study also prevented 36 children from becoming homeless this past year. A copy of Dr. Forchuk's study is included in your package.

Another study also conducted by Dr. Forchuk tested a new transitional discharge model—

Interruption.

The Chair (Mr. Kevin Daniel Flynn): That means you have a minute left. Keep going.

Ms. Pat Nashef:—which combined peer support and ongoing professional support. Findings showed that persons receiving the intervention were discharged on average 116 days earlier than those who were not receiving the intervention.

Ms. Doris Grinspun: We thank you for the opportunity to share our expertise and experiences. We ask you to lead with boldness, linking fundamental, basic needs of people with their health, including their mental health needs. Lead upstream, not downstream, is our recommendation to you. Ontario nurses are unwavering in our commitment to improve the health and health care system for all Ontarians and we wish you the best in your deliberations.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Doris. Thank you, Pat. As usual, very clear, very concise, and you used up exactly 15 minutes—very well-planned. Thank you very much for coming today. It's appreciated.

Ms. Doris Grinspun: Thank you for having us.

ONTARIO HUMAN RIGHTS COMMISSION

The Chair (Mr. Kevin Daniel Flynn): The next speaker was previously introduced in glowing terms. Barbara, thank you very much for coming today.

Ms. Barbara Hall: Thank you very much, Mr. Chair. I'm here with Anya Kater, senior policy person from the commission.

I'm really here to offer our support to you in this vital work that you're doing. We're very concerned about the level of discrimination that is faced by people with psychiatric disabilities. Because we've begun to see more cases and learn of more discrimination that exists, we've made mental health one of our strategic priorities moving forward.

We're in the process of talking with a number of people, as you are, and we'll be pleased to share our findings with you as we determine our strategic priorities with respect to mental health. We're hopeful that applying a human rights perspective can help give direction to this issue.

Using a human rights approach, I have four key points to make today. First, as we've heard from others, is the issue of stigma and discrimination. We think that has

impacted the number of people who have come to the commission with complaints about discrimination. The stigma is so great that, if they do know of their rights, it's still coming out to file a complaint that deters many people. The Supreme Court of Canada has noted that mental disabilities often create "fear and stereotypical responses in people." "A person may have no limitations in everyday activities other than those created by prejudice and stereotypes." Individuals and institutions have a legal obligation under the code not to engage in discrimination and can be held accountable for discriminatory acts. Overall, organizations have a positive obligation to take action to prevent and respond to breaches of the code.

Let me give you an example of a complaint that we worked on. Paul Lane was a quality assurance analyst in the technology industry. He was considered hard-working and productive by his employer. But when he changed firms, he didn't reveal that he was bipolar. A previous experience had shown him that the stigma of his illness could trump his record of achievement. When, eight days into his new job, he had to reveal his condition, he was terminated. Last year, the Divisional Court upheld the Ontario Human Rights Tribunal's ruling in the Lane case. The tribunal had declared that Mr. Lane's firing "was a serious violation of [his] right to be free from discrimination by an otherwise sophisticated employer that had every reason to know better." Even though he'd only been on the job for eight days, the settlement he received was well over \$100,000. His life fell apart as a result of this discrimination.

How can situations like this be prevented? I think others have said, and we would add our voice to saying this, that massive public education is key, for starters. Every organization, employer, school and service provider needs a plan and a process to ensure the needs of individuals are considered. Stereotypes about people with mental health needs need to be combated in all of these areas.

Meeting those needs is what the Human Rights Code calls the duty to accommodate and must be met right up to the level of undue hardship. The test for undue hardship is very high, with only three considerations: cost, outside sources of funding, and health and safety. In practical terms, that means employers and service providers must work with individuals to look for real solutions. The good news is that when people sit down and listen, accommodation is often quite simple. It's a question of having the conversation, entering the process. Both sides, with goodwill, are often able to find relatively simple solutions.

1640

Ontario's health care system needs to work that way too. Not only should it be designed inclusively, with the needs of people with mental health issues in mind right from the start, but it should be able to respond to the real needs of individuals through service delivery.

The second point is that we need to get rid of the silos within the health care system. We hear that a lot for a lot

of different reasons, and here's another one: Holistic approaches do work. And I know that the developing poverty strategy and the roots of violence initiatives flowing from the Curling and McMurtry report are gaining ground because that holistic approach works.

An integrated health care system is vital. Mental health and addiction services need to be built into all health care services, not seen as separate issues. By streaming people into the mental health system as opposed to the physical health system, we perpetuate the stigma that leads to discrimination and increases the isolation of people with mental health disabilities.

The Supreme Court of Canada again has recognized that discrimination against individuals with mental disabilities is unlawful. In *Gibbs versus Battlefords*, the court struck down an insurance plan that limited benefits for persons with mental disabilities as compared to the benefits provided under the plan to persons with physical disabilities. It's our position, like the court's, that such distinctions between mental and physical disabilities are discriminatory, and that same approach should be applied to other areas beyond insurance, such as health care.

We often hear that people with mental health disabilities seeking general health care services are turned away because their needs are perceived to be too complex. However, under the code, all health care providers must provide their services to the public in a non-discriminatory way.

Thirdly, we need to ensure that there's coordination across the public service. Integration and holistic approaches may start with better coordination in health care, but it needs to go much further than that. If health care workers need help understanding the issues they face there, what do we think is happening in the jails, in the courts, in policing? I think on Wednesdays there's the mental health court at College Park. People end up there because of a lack of support and services elsewhere.

Community-based programs, whether it's policing and the courts, income support—the whole range of government services—are used by people with mental health issues. There needs to be a more unified approach to delivering services there. Gaps in services create new problems for people who already have difficulty dealing with stress or navigating complex systems.

We know that people with mental health issues who can't access health care services are more likely to end up in court or in jail. Having a criminal record then impedes their ability to access employment, supportive housing or volunteer opportunities. Better coordination across sectors will help prevent these types of situations.

The fourth point I want to make is in relation to acknowledging that there are many other issues that create barriers that are within your broader policy mandate. We heard from RNAO about issues related to homelessness. Yesterday, we launched our policy on human rights in rental housing and we heard so frequently the link between homelessness or discrimination in housing and mental health. We heard a lot in that context about how the rates of social assistance are

inadequate to maintain both housing and healthy living. Income support is a major issue. It has come before us at the commission and there are cases currently before the Human Rights Tribunal dealing with issues in relation to the Ontario disability support program, which doesn't provide for special diet allowances for individuals with mental health disabilities. We're still hearing that people with addictions such as alcoholism are not eligible for ODSF, despite the multiple court decisions that have determined this to be discriminatory. I understand there's a recent appeal by the government, so once again that issue will be in the courts for potentially years.

We're looking at issues like land use planning and the fact that many municipal housing bylaws contribute to discrimination against different groups of people. Housing for people with mental health issues is an ongoing target of NIMBYism and restrictive bylaws.

We've also heard a lot about the need for appropriate supportive housing, and over and over about the unsafe living conditions that many people face. Clearly, poor housing or no housing makes it harder for people to manage their treatment and increases the risk of relapse.

Education is another area where mental health issues come up, as many children are still not having their disabilities, including mental health concerns, fully accommodated within the system. This creates the vicious circle of missed educational opportunities, having a great impact later in life when students who haven't succeeded in education are unlikely to have success in their employment situation. We also found students being disciplined for behaviour related to their disability.

In the few minutes I've had to speak to you today I've raised four points. I guess I could easily have spent the time talking about the needs of children with mental health problems and the need to identify and address those problems earlier and more effectively. I know others have done that.

In spite of all the problems that I've spoken to, I think there is some good news. There are more people addressing the stigma and discrimination. We're moving towards more effective holistic solutions.

At the commission, we are now focusing on systemic discrimination, and getting to the roots of discrimination and the necessity of multi-faceted approaches to discrimination becomes more and more obvious to us every day.

We are delighted that this all-party select committee has taken up the challenge and we look forward, in the months and years ahead, to working with you to contribute our expertise and experience as we look for better ways to deal with the many, many Ontarians who live with mental health issues.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much. An excellent presentation, as we knew it would be. You've used up all your time, unfortunately, so there's no time for discussion, but you made your points very clearly. Thank you.

1650

MARK DUKES

The Chair (Mr. Kevin Daniel Flynn): Our next presenter today is Mark Dukes. Mark, if you'd like to make yourself comfortable there. Like all the other presenters we've had before us today, you get 15 minutes to use any way you see fit. If you would like to leave some time at the end for some questions and answers, that works well, but if not, how you use your time is entirely up to you. The floor is all yours.

Mr. Mark Dukes: Thank you. Hi, everybody. My name is Mark Leannele Dukes, and in my 36 years of life I have lived in Toronto, Cobourg, Belleville, Kingston, Trenton, Peterborough, Orillia and, finally, back home to Toronto. To be fair, I've been intoxicated in some fashion or another throughout my life, so dates, addresses and employment are hard to recall, but I'm sure I've got the cities right. Good afternoon, everyone.

I've come here today to discuss my perception of addictions within Ontario, although I have concurrent disorders right now—I suffer from a mental health issue and addiction. I've come here to propose opportunities for change. I propose these changes not as a peer, a consumer of services or a survivor of addiction, but as a current drug user. I base my proposals upon my personal experience with addiction as well as four solid years of working with some of the top addictions stakeholders of not only Toronto but the country. I sit as the drug user representative on the Toronto drug strategy implementation panel for the capital of the province, but I don't represent them here today; I'm just an individual who does drugs.

The Toronto drug strategy addresses issues of addiction in four main categories: law enforcement, treatment, prevention, and last, but certainly not least, harm reduction. In my time spent analysing these four methods for positive addiction intervention, I have come up with opportunities for change within these areas that I would like to share with you now. But before I begin, I want you to all know that throughout my advocacy and my volunteering of time, I've tried to remain non-partisan within the issue of addiction, so I would accept funding from any one of you here to get the job done. I don't discriminate.

First, I'd like to begin with my recommendations in law enforcement. I see two major opportunities for change that would help not only the drug user, but the community that they live in. I propose that at least a reasonable percentage of all proceeds of crime that are seized from drug crime by both provincial and municipal police services be directly applied to the other areas of positive interventions in addiction; namely, treatment, prevention and especially harm reduction. Simply put, take the supply-side drug money that is seized and use it to fund the demand-side addiction services—it sounds pretty simple. I will be engaging the Senate concerning this issue and hope that with your collective help, we can

increase the funding towards helping the communities dealing with addictions, but most importantly, the user.

Secondly, I will point out to the committee the high percentage of times a call to 911 within Ontario involves an aspect of drug or alcohol use. Considering the economic situation that we all find ourselves in—I know that money doesn't grow on trees, although it's made from them—doesn't it make sense to divert people with addictions to health services instead of jail or overcrowded hospitals? I think you could save money; I really do.

So in that frame of reference—saving money—I propose a new division in labour within police services across the province to be created to address addiction issues specifically. I do not mean drunk driving or meth or crack labs or violence involving drugs or alcohol. What I'm talking about is instituting a new division in labour that is modelled after the already-existing mobile crisis intervention team. We have one of those in Toronto. It's a nurse and a police officer. So I'd like that for addictions as well. I guess that's what I'm really saying to you.

The law surrounding addiction in Canada has just changed. Although Ontario is appealing the decisions surrounding addiction as a disability, I expect that, if and when the appeal is struck down, this proposed division in labour will be instituted in order to reflect the Charter of Rights and Freedoms, specifically the parts concerning discrimination and safety of the person. If people with mental health are handled differently by enforcement, then why not people who are addicts?

Treatment: Once again, no new money means innovation with existing infrastructure. I see treatment in three phases, personally—I'm not a doctor or anything. I see it in three phases: first contact; acute or chronic care; and maintenance or aftercare. The two phases that I would suggest updating would be first contact and aftercare. Regardless of whether you are in urban or rural settings within Ontario, your first contact in dealing with your substance-use issues should not be getting arrested. That would only lead to more criminalization, institutionalization and stigmatization of a person who essentially needs help or support. My proposal of a new division in labour of the police services could actually change the first contact from an arrest to an assist for those suffering from addiction.

As far as the aftercare, I would suggest partnerships between large and well-funded hospitals and health centres and their community counterparts, which are the street-level community services—drop-in centres and the like. These types of partnerships create the kind of continuity an individual experiencing addiction needs to receive consistent health care.

Prevention: In my opinion—and I really stress this this time; this is only my opinion—the biggest opportunity for change that I can see for this area of positive intervention is the funding—not the amount of funding, but the ideology and the process that the organizations applying for the funding have to go through in order to get it.

Let me just define what I mean by that. The fact that the province is funding normally one- or three-year projects only encourages organizations to take the easy road. In order to get the win, they create a pilot project that is going to win, not the one that they should be creating that potentially might not win but helps the people who are most directly involved, like street-level users. Phrases like, "We need to make our pilot project successful and viable and attractive to the government so we can get more funding later"—I hear phrases like that and I just refuse to accept them. This kind of reasoning, which I have witnessed, makes economic sense but, again, encourages organizations to take the easy road and give you what they think you want versus what they should do. I suggest we take the high road and prevent communities and youth already involved in drugs and drug use from further involvement. I would like the province not to look into after-school programs for at-risk youth, but instead call for a proposal for educating youth who are already at risk and preventing them from future use. There again, I see a natural partnership between law enforcement and health services.

1700

As promised, last but not least, harm reduction: It saved my life, harm reduction. The RIDE program, regular checkups at your doctor's office and handing out clean crack pipes and needles are all a part of this area of positive intervention, and they are all vital services that address harms associated with alcohol and substance use. It is my opinion, though, that discrimination and stigma associated with alcohol and drug use far outweigh all the rest as being the biggest harm and obstacle to stability and recovery of an individual or communities affected by addiction. Isn't that why you're all here together as a committee?

The fact that there is no argument concerning the need to create a strategy to deal with addiction and mental health—I think it's great that you all came together.

Just give me another second. Sorry; it's kind of personal.

The Chair (Mr. Kevin Daniel Flynn): You've got all sorts of time left, so just take the time you need.

Mr. Mark Dukes: All right, thank you.

To continue, if it's your intention to create a strategy to deal with addiction and mental health, I ask you all to directly involve drug users within the solution and not just the problem. I'd like to see drug users involved at every level, from policy creation to policy implementation and then on to the evaluation of that policy.

I have always been accused of being a dreamer, and although my visions are grand in design, I hope you all agree that we can accomplish any of these things I just mentioned if we are inclusive throughout the process. If all of these parties in front of me here today can come together to create a strategy that affects me directly, then I can at least find the courage to step from the safety of the shadows of stigma and reveal myself as someone most directly related to the issues of addiction—a drug user. Thank you. Any questions?

The Chair (Mr. Kevin Daniel Flynn): I'm sure there will be. We'll start with the NDP. We've got about three minutes left.

Mr. Rosario Marchese: Thanks very much, Mark, for your presentation. I agree with a lot of what you said, particularly with issues of prevention and treatment. It's always the case that we spend less money and attention on prevention, and we spend less time and money and attention on treatment as well.

There are many in society who just want to be able to punish someone as soon as something happens rather than finding out what the problem might be and what we could do to help, and what we could have done to prevent it. It's a difficult challenge for many, particularly those like you who are telling us what we should be doing. I agree with your presentation; it makes a lot of sense. I hope we can get to some of the suggestions and recommendations you're making.

Mr. Mark Dukes: Me, too.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Rosario and Mark. Any questions from this side? Bas?

Mr. Bas Balkissoon: Mark, thank you very much for your presentation. The committee had an informal discussion earlier today, and you raised a good point about first contact and criminal charges. How do you see the system working to recognize someone with mental health or an addiction at that first contact point and redirect them out of the justice system?

Mr. Mark Dukes: Not to be smart, but common sense would be the first thing. Your question was, how would you—sorry, once again? How does somebody identify somebody who's experiencing—

Mr. Bas Balkissoon: How does the system identify a person on first contact and redirect them out of the justice system so that they don't get into the justice system and they don't have a criminal record?

Mr. Mark Dukes: Right. My idea on that would be that—I referred earlier to consistency and continuity. Within the health industry, it's kind of scattered in silos, as somebody referred to earlier. The person involved directly—the drug user—has to sign a piece of paper everywhere they go. Pretty soon, you get tired of signing pieces of paper, or certain pieces of paper aren't signed, so therefore organizations can't communicate back and forth.

The continuity of information between those existing systems out there doesn't exist, so that person kind of bounces around, and maybe information catches here and there. You need to organize yourselves accordingly in terms of communication and continuity for an individual case. You have one case file, but in a region or an area, you need somebody who knows where these people are going, what they're doing and what's happening throughout the day. That's the identification.

I would assume that people who are in emergency services, fire, police and ambulance, upon entering a situation, know what's going on. They've seen it a million times before.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Mark. We're going to go on to Christine.

Mrs. Christine Elliott: First, I'd like to thank you very much, Mark, for coming today and talking about something that's obviously very difficult for you.

I'd just like to carry on a little bit on the justice side, and I agree with you that some of the diversion teams, where you have a police officer and a mental health or addictions nurse going out, seem to be very effective where they're working in areas of the province, but there are some situations where there may be some charges that are going to be laid that can't be diverted.

I've had an opportunity to attend—we have a drug court where I live, and it seems to be a good way of almost harm reduction for certain people who choose to enter into it in the sense that it helps people along the way and helps them to sort of deal with the addictions issue. Could you just give me your opinion on it? Do you think that it's a useful investment?

Mr. Mark Dukes: Firstly, I will stress again that I'm going to make a distinction between mental health and addiction. I think if you were to create such a thing, you would look at the model that already exists, but addiction is different in many forms. Including some of the charges that you alluded to earlier, concerning the ones you can't—you walk up and you knock somebody out. Regardless of the fact of whether you're drunk or stoned, you're going in the bin, right? I understand that.

What I would like to see and what's already happened—I think we need to create a status here. People have been stigmatized within this issue for years, they've been institutionalized for years, and going through that wringer over and over again, the police run the routine and so do the addicts. There needs to be a break in that habit. The people who are the victims in the war on drugs need to be pulled off the battlefield and the cops and the drug dealers need to go at it. I'm in full support of that.

In answer to your initial question, I would love to see a nurse out on a street talking to somebody with addictions as opposed to somebody with a gun.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today, Mark—an excellent presentation, very well received.

Mr. Mark Dukes: I hope so. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you.

PEEL CHILDREN'S CENTRE

The Chair (Mr. Kevin Daniel Flynn): Our next presenter this afternoon will be from the Peel Children's Centre: Humphrey Mitchell, the executive director. If you'd like to come forward, Humphrey, make yourself comfortable. Any one of the chairs has a live mike. Sit wherever you like. There should be some clean water—well, I'm assuming the water's clean. The glasses should be clean as well.

Mr. Humphrey Mitchell: Thank you. We'll see what we can do.

The Chair (Mr. Kevin Daniel Flynn): Make yourself at home. You've got 15 minutes like everybody else, and you can use that any way you see fit. If you can leave some time at the end for any questions, we'll see if we can split it evenly. Thanks for coming.

1710

Mr. Humphrey Mitchell: Thank you very much. I appreciate the opportunity to speak to you today.

You've heard many presentations already and covered many different gambits of the issue of addictions and mental health. My focus today is going to be in the area of children's mental health and youth mental health. I've spent the last 30 years of my career working in this field, so that's going to be the area that I will focus on today. I have five different areas that I'd like to speak to you about. I'm going to speak not from a clinical perspective, but more from a systemic perspective, because I think that is one of the issues that I think we struggle with and, at a higher level, is something that recommendations coming out of the committee can probably make a profound difference in in terms of mental health and addiction services throughout our province.

First, ensure equitable access to mental health services for all children, youth and adults throughout the province of Ontario. It sounds simple, but it's a very complicated and challenging issue. I come from the Peel community. We've had dramatic growth, as many of the 905 areas have had, and historic funding patterns have not kept pace with the growth. If you look at rural communities in the north where you have people who live great distances, access to mental health services, whether it's children or adult mental health services, is wildly different. I strongly believe that what we need is a formula that's predominantly based on population, that takes into consideration key proven social indicators that we know contribute to mental health challenges, and also, for our colleagues in rural communities and northern communities, something that takes into consideration the distance factor. But to have truly accessible mental health services for children, youth and families in this community, what we need is a formula that in fact will be equally distributed, with certain variations, across the entire province. For a child living in Peel to receive \$1 for every child living in Toronto receiving \$6, simply by division of the Etobicoke Creek, really doesn't make sense in terms of mental health differences. The poverty situation, the diversity situation, in the Peel community is very, very similar to that in Toronto and the differences just don't justify that kind of difference in terms of funding.

Secondly, integrate the child and adult mental health systems. The David Peterson government, in the late 1980s and early 1990s, just before Mr. Rae took over, was on the cusp of taking a strong stand and moving forward in integrating the adult and children's systems. It's unfortunate it didn't happen, in my opinion. What we have right now is what I would call a conveyor belt. Children's mental health provides services up to the child's 18th birthday. At that point in time, the child goes into a free fall. A lot of the children we work with are going to

need mental health services for the balance of their lives, so to have them change systems from the Ministry of Children and Youth Services to a Ministry of Health and Long-Term Care structure, in my mind, really causes—the more seams you have, the more chance to fall through the seams. Thistletown Regional Centre, which is directly operated by the province of Ontario, has, I think, 10 or 12 adults between the ages of 28 and 38 who are currently being served in its triad program simply because there's nowhere in the adult system for them to go. Whether it's a formal ministerial approval or a linkage, or whether it's some kind of formal linkages approved throughout the province on a consistent basis, we need to link these two systems so that we don't have children and youth fall through the cracks on their 18th birthday.

Thirdly, create a universally available province-wide continuum of mental health services. I know it sounds complex—and one of the speakers I heard earlier today was saying there are models in Australia, there are models in the States, there are models in Europe. There are models available that we can learn from. They may not be perfectly applicable to our Ontario situation, but there are models that will tell you what kind of services should be available, all the way from the prevention side to the most intensive intervention side and everything in between. We know from years and years of studies and research that if you don't provide every level of service along that continuum, you'll either over-serve at a higher cost a particular child or youth, or you'll underserve at a much greater risk for that child or youth in terms of their mental health needs.

Fourthly—and the last two areas I'm going to talk about are really around what I would call efficiency and economic savings. We always talk about wanting more money, and I know it's probably a mantra you hear often. I think there's a way our systems can be better operated, even with existing dollars. I'm not saying we don't want more money in the system, but I think they can be better operated.

Realign geographic catchment and planning areas, both across and within ministries and ministry-funded service providers. As a service provider, we're being asked to sit on multiple LHINs that are available now, new catchment areas that have been created. In the Ministry of Children and Youth Services, we have a central west region. Even within that same ministry, the youth justice portfolios, the children's mental health portfolios and the child welfare portfolios have different catchment areas. Our school boards have different catchment areas. I realize that we will probably never have one that's perfect, but if I look at the amount of time—recently I was talking to a senior vice-president in one of the Halton hospitals, saying that their senior staff are spending upwards of two days a week representing the various LHINs. You look at the amount of time that's going into the planning, and there are different planning cycles for different groups. We need something that's cohesive and, I think, can be much more effective and much more efficient in terms of delivery of service.

Lastly: Rationalize the number of providers with mental health services throughout the province. This would not be popular amongst some of my colleagues. In children's mental health, there are over 400 providers of children's mental health services funded through the Ministry of Children and Youth Services. I would say to you, in my not so humble opinion, it's far too many. I know the recent consultation, Every Door is the Right Door; I would say, in this province, we have too many doors. I think it's convoluted; it's confusing for consumers. The consumers, at a point in time of need, don't know where to turn, and we need to simplify this in the community. I would also say to you, by virtue of having fewer providers, you're going to have a greater level of expertise in a whole host of areas, all the way from your administrative infrastructure to your clinical areas. Multiple small agencies can fit niche markets and they can continue to be niche, but you need some way of linking them so that in fact they can have the benefits of a larger system.

I would be glad to answer any questions you would have, but those were the five points that I wanted to make. I just wanted to thank you again for the opportunity to speak with you today.

The Chair (Mr. Kevin Daniel Flynn): Wonderful. Thank you. You've left about two and a half minutes for each of the sides. Liz?

Mrs. Liz Sandals: You've raised a number of interesting issues. One of the issues that we've talked about—interestingly, not just from a mental health point of view and the confusion around what service is provided by whom but also from the public accounts point of view—is, is the money being spent effectively? Have we actually got the province covered? So there has been a lot of conversation about rationalizing the number of agencies. Practically speaking, what would you see as key steps in going about that?

Mr. Humphrey Mitchell: I think there's a good opportunity for government to create some incentives for organizations to come together. I remember Minister Chambers saying she was shocked at the children's mental health conference—I'm not here to talk about amalgamation and mergers. I don't think amalgamation and mergers are bad, as long as they are done for the right reason. I think there are opportunities, in terms of strategic directions. We have a strategic direction with Nexus Youth Services that allowed Nexus Youth Services to continue to have its own identity, but it gets the benefit of a larger infrastructure that we can provide. So they have access to psychiatry, psychology, human resources and information technology, which they just never would have access to as a small agency of four or five people.

I think there are opportunities to create this that will really bring people forward. Not everyone will want to play, to be honest, and at some point in time, I think some decisions have to be made. But I do think there is a critical mass, that there is a level of efficiency to be

gained, and without that, I would question whether in fact it's viable to continue, to be honest.

Mrs. Liz Sandals: Thank you very much.

The Chair (Mr. Kevin Daniel Flynn): Sylvia?

Ms. Sylvia Jones: I wanted to delve a little deeper into your fourth point about realigning geographical catchment and planning areas. I've heard the LHIN issue before, in children's mental health, of course. You've added that other component of the schools etc. What do you envision in terms of how you would look at that realignment?

Mr. Humphrey Mitchell: That's your job.

Ms. Sylvia Jones: That's why I'm asking you.

Mr. Humphrey Mitchell: No, it's a huge task, and I don't have a cookie cutter, but I think, within the province, it's not unreasonable to think that you have a provincial level, you then have perhaps what I would call regional levels and then you have local area levels, and they should be consistent across, as much as you can, school boards, hospitals, for all our planning so that when we come together, we come together once with a focus on a particular geographic area—the same population. We can talk about the demographics for our community and we're all talking the same language. Right now, it's highly fractured. I didn't mean to be glib. I don't have a magic formula for what those structures should be, but I really think it's critical and I think there are huge, potential efficiencies if this can be done.

1720

Ms. Sylvia Jones: I can see why you would be frustrated because even within the LHIN systems, they have different priorities; they have different areas that they want to focus on in terms of for their catchment area, for lack of a better word. Looking at your organization, where you're dealing—do you have three LHINs?

Mr. Humphrey Mitchell: Two.

Ms. Sylvia Jones: Two—that you would have very different wants and needs coming from the LHIN system.

Mr. Humphrey Mitchell: Please, I'm not being critical of the LHINs in any way, shape or form; I just use them as examples of different structures and different geographic boundaries.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Humphrey. France?

M^{me} France Gélinas: Your second point, “integrate the child and adult mental health system”: Do you see it as high as having a ministry for mental health, or do you see this more as integration at service delivery or anywhere else in between?

Mr. Humphrey Mitchell: I think it can be done in different ways, but I think it has to be done. In 1979, children's mental health services moved from the Ministry of Health to the Ministry of Community and Social Services. I think there are benefits both ways. I think the creation of the Ministry of Children and Youth Services has had some benefits with it. I would be one to say that maybe it hasn't gone far enough. But even if children's mental health continues to be funded from that ministry, we need some formal linkages that are province-wide—

it's not just left to local areas to figure it out—that are given, are confirmed and you can really count on.

We have children going from one part of this province to another part of the province, and the ability to access those services is dramatically different. The same thing happens as people go from—if you think of people, often at age 18 they're going to community colleges. They maybe go to universities. And what they're being exposed to, again, is dramatically different in different communities throughout our province. Just to have an alignment that is consistent everywhere throughout the province, or as much as you can, I think would be wildly beneficial for people in this province.

M^{re} France Gélinas: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you, France, and thank you for coming today, Humphrey. It certainly was appreciated.

Mr. Humphrey Mitchell: Thank you very much for your time. Good luck in your deliberations.

SHERBOURNE HEALTH CENTRE

The Chair (Mr. Kevin Daniel Flynn): Our next speaker today is from the Sherbourne Health Centre, Suzanne Boggild?

Ms. Suzanne Boggild: Boggild, yes, thanks.

The Chair (Mr. Kevin Daniel Flynn): Close. Please make yourself at home there; introduce your colleague. You get 15 minutes like everybody else, and you can use that in any way you see fit. If there's any time at the end, we'll do what we just did and see if we can split it amongst the three groups.

Ms. Suzanne Boggild: Great. Thank you very much. Good afternoon. As I said, my name is Suzanne Boggild. I'm the CEO of Sherbourne Health Centre. With me here today is Jothi Ramesh, one of our mental health counsellors who has helped build our mental health program at Sherbourne. I want to thank you very much for giving us this opportunity to provide you with some of the background on the important work we do every day at Sherbourne Health Centre to help those with mental health and addiction issues.

You'll see from our report that I've organized our recommendations under three broad strategies. I'll go over these, and then Jothi will highlight a case study based on our actual experiences at Sherbourne. We hope this case study will actually bring to life for you how our recommended strategies, we believe, really improve client and system outcomes.

First, I'd like to give you a little bit of an idea about Sherbourne Health Centre. We're an urban primary care centre. We've been serving southeast Toronto—just really down the street from here—since 2002. We focus on three distinct populations: homeless and underhoused individuals, newcomers and immigrants, and members of lesbian, gay, bi and trans communities. You'll see from the chart in our presentation that since our inception in 2002, our client visits have grown dramatically. We've found that approximately 50% of our clients raise mental

health concerns while receiving primary care. We believe that this rapid growth and success with our mental health service within a primary care setting gives us credible experience on which to base our recommendations.

Our first recommendation is that you enhance mental health services within primary care. We certainly understand that governments cannot ignore the needs of other parts of the mental health and addictions care continuum, but we believe that improving the way government approaches and funds primary mental health services must be a cornerstone of your report and recommendations. When mental health services are embedded within primary care, we believe there is less negative stigma attached to mental health care, thus leading to earlier interventions and more voluntary care. We also believe that primary mental health care increases the likelihood of client commitment to their care regime and it normalizes mental health issues within a health promotion and chronic disease management framework. So we believe this improves both physical and mental health, which we believe have been somewhat artificially segregated for too long.

We certainly support a continuum of care and we know that should clients need more specialized care, the primary care team needs to serve as a system navigator, case coordinator and often, a knowledge translator.

The good news is that Ontario already has a good network of primary care providers. There's a growing number of family health teams, as you know, across the province, and community health centres are growing as well. We believe that incremental investments within these existing structures have the potential to leverage big gains for the people of Ontario and the health system. That's our first recommendation.

Our second recommendation, and one which Jothi's case study will highlight, is the need to recognize the particular importance of health promotion strategies and illness prevention initiatives in newcomer and immigrant communities. Our experience with many different newcomer communities convinces us that there are multiple and particular barriers to receiving care for individuals within these communities. We believe that at the primary care level, one needs specific community engagement strategies and targeted health promotion activities, especially if they're integrated with physical health, in order to lead to earlier intervention and acceptance of mental health care within newcomer and immigrant communities.

We're certainly happy to talk about how we serve our other populations from a mental health point of view, but today we wanted to highlight the challenges within newcomer and immigrant communities. You'll see that our paper gives a couple of examples of what we think are low-cost and high-value initiatives with immigrant youth and newcomer moms that have led to very positive mental health results. That is our second recommendation.

Our third recommendation is that the select committee support more mental health training and development of primary care teams. Again, the good news is that there is

already a platform for this within Ontario, and we believe HealthForceOntario is that platform. We believe it could be the tool the government uses to meet this recommendation. One of the goals of HealthForceOntario is to build on the skills of those already in the system.

How to build on those skills? We believe that primary care teams need the skills to engage clients in mental health promotion, to undertake mental health assessments and ongoing treatment, to refer to specialized mental health resources, and very importantly, to partner with communities and other organizations to improve mental health promotion at the population level.

In order to succeed, we believe that primary care needs: access to psychiatrists and psychotherapists for case consultation; funding formulas that support case-conferencing by a group of interdisciplinary professionals; opportunities for individual clinical supervision; and opportunities for multidisciplinary team development.

That is our final recommendation. Now I'll ask Jothi Ramesh if she'll paint a picture of how these recommendations can work on the ground. I want to emphasize that the case study is, of course, an amalgam of our experiences at Sherbourne Health Centre and it in no way identifies a real client.

Ms. Jothi Ramesh: Thank you, Suzanne. The following case study illustrates the importance of the three strategies we are advocating. The case demonstrates the importance of the integration of primary health care and mental health care, supports the value of care developed for newcomer/immigrant populations and illustrates the positive outcomes available to clients of well-trained and clinically supported teams.

The outcome for this client was positive, as the treatment approach helped to keep the client out of the emergency department and in-patient units. The facts of this case have been altered to ensure this client could not be identified.

Mr. S is a 50-year-old man who emigrated from Eritrea 10 years ago. He was living in a market-rent apartment and working part-time as a security guard. He's married and lives with his wife and son. Mr. S was educated as an engineer in Eritrea but had been unable to find work in his field.

Mr. S was referred to the Sherbourne Health Centre through a settlement worker who had made contact with a counsellor at the Sherbourne Health Centre who spoke Arabic. The counsellor at the Sherbourne Health Centre, Ms. R, met with Mr. S and was able to communicate with him in Arabic. It became clear that Mr. S had been in crisis for some time.

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Mr. S had been under severe financial stress for many years. Due to his difficulties finding employment, Mr. S had to rely on money from his brother to pay his monthly expenses.

In the six months prior to being seen at the Sherbourne Health Centre, Mr. S began feeling suspicious of people. This increased to feeling like people on the street were laughing at him and he was hearing voices. These

symptoms made it extremely difficult for Mr. S to sleep. He began to drink alcohol in order to get some sleep. Mr. S's situation escalated to the point where one evening, after consuming some alcohol, he had a verbal and physical altercation with his wife, and the police were called. Mr. S was charged with assault and the court appearance was pending.

At the time of initial contact with Mr. S, the counsellor at the Sherbourne Health Centre was able to ascertain that Mr. S had a serious mental health issue. The health centre had a psychiatric consultant employed for case consultation. This psychiatrist was able to see Mr. S within a week, and this was very important because the counsellor acted as an interpreter during the assessment.

Mr. S was then referred to the family health team for follow-up. He received prescription medication to help him with his paranoia and sleep. This was prescribed by the family doctor after he had consulted with the psychiatrist, so it was a team working with him. Mr. S also benefited from ongoing supporting and counselling from Ms. R, who was able to speak with him in Arabic.

As time went on, Mr. S gained some weight—this being a side effect of the medication—and he was referred to the nurse and the dietitian at the family health team to offer him some education around his diet and overall well-being.

Mr. S was able to have his court matter diverted through the mental health diversion program. He returned to work part-time, and he reunited with his wife after receiving couples therapy.

He's still on medication and his symptoms have improved greatly. He still takes alcohol on and off, but it has been a great positive outcome because it reduced costs—going to emergency departments all the time or getting in-patient care. This was possible only because we had a team working together and we intervened right at the very beginning.

Ms. Suzanne Boggild: Thank you very much for your attention. I hope our presentation demonstrates how Ontario can use existing platforms, namely our primary care system and HealthForceOntario, to give the people of Ontario better local access to mental health care and how small investments in primary care team training and development can lead to more accessible, culturally competent and ultimately more affordable mental health care.

Again, I thank you for this opportunity to make our recommendations, and we welcome your questions.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Suzanne. You've left about three minutes, so about a minute for each party. Christine or Sylvia?

Mrs. Christine Elliott: Thank you very much for your presentation and for highlighting particularly some of the issues that you face with newcomer clients. In the particular case example that you gave us, the counsellor happened to speak Arabic, so it worked out. Do you often encounter situations where you have translation issues and problems in communicating with your clients?

Ms. Jothi Ramesh: Yes, but we do have some counsellors who speak some of the languages that represent

our population that we're serving in the catchment area. But we do run into situations where the client does not speak English and we don't have a counsellor who speaks that language.

If you look at counselling, it's a one-hour appointment every week. Our funding does not allow us to provide translation services—it's quite expensive—so we'll have to refer them out if they can't speak. We have phone translation to do intake to provide some support to help them with the referrals, but to carry it on—because we have open-ended counselling, too, so it's—

The Chair (Mr. Kevin Daniel Flynn): Thank you. We're going to move on to France.

M^{me} France Gélinas: It sounds like a wonderful model. Where does your funding come from for the Sherbourne Health Centre?

Ms. Suzanne Boggild: We're funded both through the Toronto Central LHIN and through the Ministry of Health through our family health team, and then we have funding through other aspects of the Ministry of Health. We receive a little bit of private funding and have had one-time grants from the federal government and from the city as well, but our core funding comes through the Ministry of Health and the Toronto Central LHIN.

M^{me} France Gélinas: Do you charge for any of your services?

Ms. Suzanne Boggild: No, we don't.

The Chair (Mr. Kevin Daniel Flynn): Thank you, France. Jeff?

Mr. Jeff Leal: Thank you very much for your detailed presentation. Do you see the family health teams as being one of the principal platforms to extend both services and assessment in the province of Ontario? We have about 150 that are functioning today and functioning very well. Additional investments on that side of it to address things that you've identified, you believe, is one of the ways we should go.

Ms. Suzanne Boggild: Absolutely. I've really had the pleasure of developing, with other folks, the family health team at Sherbourne and being engaged in the family health team initiative across the province, and I think it's an excellent platform to build in more primary mental health. I think we underestimate how stigmatizing mental health can be. I think it's a very positive way within local communities for people to engage around their mental health, both prevention, promotion and treatment.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today. It really is appreciated.

Ms. Suzanne Boggild: Thank you very much for your time.

CANADIAN MENTAL HEALTH ASSOCIATION, TORONTO BRANCH

The Chair (Mr. Kevin Daniel Flynn): Our next presenter today is the Canadian Mental Health Association, Toronto branch. Steve, if you'd like to come forward—Steve Lurie, executive director. Make yourself

comfortable. Like everybody else, you have 15 minutes. Use that any way you see fit.

Mr. Steve Lurie: Thank you very much for inviting me. I started out my career in mental health working in Christine Elliott's riding at Mental Health Durham in 1975. For the last 30 years, I've been here in Toronto providing services in part to Scarborough, where Bas Balkisssoon, as you know, works and lives. During that period, I've had a great opportunity to also work on some of the policy initiatives in this province and also some of the Canadian ones, so my presentation today is going to focus on those. I was involved in developing the first mental health strategy for Ontario, Building Community Support for People, by Bob Graham in 1988. As a result of that—or as penance—I became the Ministry of Health's coordinator for mental health and addictions and contributed to what was then Putting People First. Then I was on the provincial advisory committee on mental health that contributed to the Conservative government's strategy, Making it Happen. In 2005, I provided some assistance to Senator Kirby with his committee. Since then, I've been chairing the service systems advisory committee for the Mental Health Commission of Canada. In my spare time I also teach health and mental health policy, so what I'm going to try and offer you is actually evidence-based, to some extent.

What I've decided to try and focus on is the need for a 10-year investment in a mental health and addictions strategy. I know that with what's going on today, there are a lot of discussions about value for money, but I honestly believe that a focused investment plan on the right things will actually provide value for money, especially for those people and their families who live with mental illness or addictions. I might say that mental health and addiction live in my family, so I can tell you that that had good care been available, in many cases, tragedies could have been avoided.

What I've tried to do is divide my presentation into the why, what and how.

Why should we do this? You've heard eloquent testimony since you've been set up as a committee that mental illness and addiction affects 20% of Ontarians each year—that's the people directly affected. If you estimate families and friends, it's a far higher number. Regrettably, only three in 10 get any services at all, and of those that do, 50% don't get what they need. People with mental illness die 25 years earlier than the general population. According to the material prepared for the minister's mental health and addiction strategy, mental illness has overtaken cardiovascular disease in terms of the leading cause of disability, and it has huge costs in law enforcement. Also, mental illness accounts for one third of the hospital days across Canada and likely in this province, and we could reduce that significantly by putting in place more of the programs that are already working. As the Every Door Is the Right Door document said, for every \$1 invested in mental health and addictions, there's a \$7 reduction in health costs and a \$30 reduction in social costs.

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Also, in what used to be one of the most prosperous provinces in the country and is what is supposed to be the fourth-best place in the world to live, we have the lowest proportion of mental health spending of any of the OECD countries, and that includes Ontario—5%. The goal should be 10% to 12%. As I actually uncovered for the Graham committee 20 years ago, the mental health share of spending in Ontario is still declining, as it was 20 years ago. To make that apparent, in the last mandate, the Ontario government added \$8 billion in spending to its health care budget; of that, \$200 million went into mental health; so, far less than the actual need. That's not to say that the services weren't welcome and needed, but proportionately, mental health didn't get the bulk or anywhere near its share of mental health spending.

If you look at the costing for Out of the Shadows at Last, where they proposed a \$5.3-billion investment in mental health services across the country, Ontario's share of that would be \$800 million over 10 years, and a commitment by the government to implement an \$80-million funding increase over a 10-year period each year would actually increase only 1.5% of health spending. That is just over one tenth of 1%. So the question is, I think as Doris Grinspun said, "How can you afford not to?"

The other evidence-based finding in this—and I'm sure you've been given the service enhancement evaluation research project that was done—is that the \$200 million that was spent actually paid off in terms of better outcomes for people, families and communities, but it was insufficient to leverage system change. For example, we know that court support programs and crisis intervention teams work. I just had a look at the court database—we provide court support services in Scarborough and in Finch West—and only a third of the people coming through those services had ever been connected with a case management program, whereas over 65% of them had previously been in hospital and over 60% had been on psychiatric medication. So people are just moving in and out of the institutions but not getting connected with the community services.

So, what should you be investing in? Well, I've given you a pretty extensive list: peer support—culturally and linguistically; responsive services, as you heard in the previous presentation; case management; and assertive community treatment. We already know that for each ACT team you put out there, you can dramatically reduce hospitalization. Last year in this province, out of about 4,300 people, there were 65% who spent no days in hospital when previously they would have spent 50 days a year in hospital.

We need 23,000 more supportive housing units, and that's just taking the estimates from the Senate committee report and looking at Ontario's proportionate share—and that was developed by CMHC, not CMHA. They looked at the number of people who are housing-deprived relative to the population in Canada and came to the conclusion that people with mental illness were more housing-deprived than the rest of the population. So

57,000 units would at least get them to the level of the rest of the population. Ontario's share would be 23,000. Putting that in perspective, in 1999, we estimated that 14,000 supportive housing units were required. Today, in Toronto, we just completed a study on supportive housing, and, if you apply for supportive housing in Toronto, there are 4,300 units, approximately, that have taken over 30 years to develop, but you have a two in three chance of not getting in, simply because they're full.

We run a safe bed program, and regrettably, we now have to discharge people from the safe beds, where they come through the justice system, out of jail. They get 24-hour support; they can stay for up to 30 days. We have to discharge many people to the hostels, which isn't the way it should be working. We need more supportive housing.

We need more systems research and technical support. There has been a good initiative: The service enhancement research project actually cost less than 1% of the money that was spent, and it provided really useful information for clinicians, community planners, the LHINs and the ministry.

As Suzanne said previously, improving access to primary care and chronic disease management would be a very important thing to do, and you can do it two ways: by increasing the capacity of the primary care system to provide mental health services, but also—and there are some wonderful examples here in this province. I'm assuming that when you were in Windsor you heard about the work that's going there at CMHA Windsor, with one nurse practitioner and now a community health centre embedded in the community mental health service. You can get tremendous results. So it's not one size fits all; it's a both/and support.

I want to remind us that poverty is a huge issue for people living with mental illness. Our ODSP payments are 43% of the low-income cut-off. You have to do something about that. A 2% raise a year leaves most people in poverty. An apartment in St. Catharines, your own apartment, costs \$700 to \$800 a month and the ODSP allowance is \$900, so it doesn't leave much room. Think of how much of a problem that is in Toronto.

How would we do this? I want to take issue with my friend Humphrey Mitchell. I think it's more important to support collaborative planning and service delivery that focuses on connection at the front line in local communities than to unleash a 10-year initiative to merge organizations. You should look at the evidence of the Health Services Restructuring Commission as to whether that really improved hospital services. I'll send an article along to your clerk that I did and was just published and shows that actually, in the private sector, 80% of mergers fail. Even strategic alliances have a failure rate of 60% to 70%. There are ways to make these things work, but the evidence is not there that administrative restructuring improves clinical care systems. If you don't believe me, I would quote Henry Mintzberg, who is Canada's leading expert on strategy.

I think it's really important that we enhance capacity for peer-led services; that may be the game-changer.

There's a lot of that going on in our LHIN: programs like Wellness Recovery Action Plan. Plans run by consumers, pulling them together, really have a potential to both empower people to learn how to manage their own illness symptoms as well as keep them out of hospital emergency departments.

It's important to have a whole-government focus: one ministry alone can't do this. I was impressed to see that the minister's strategy involved other government departments, and that needs to be a recommendation of your committee. One department alone can't do this.

There does need to be a focus on the justice system, not only from a cost perspective but also because of the benefits of working together. I actually have been chairing the Toronto Human Services and Justice Coordinating Committee for the last 12 years. It's a lot of work that my colleagues and I do across the province, but we really are beginning to build partnerships with the justice system. The SEEI reports that I've mentioned previously point to some of the good work that has been done and some of the learnings.

It's important to establish benchmarks based on evidence and encourage service quality, not only at the system level or the LHIN level but within organizations, because organizations and programs are what can make a difference in how a service is delivered. Let me give you an example of this: If you were to go on to the health indicator tool from the Ministry of Health and look at what the average cost of case management services is, you'd see a figure of about \$1,750. If the LHINs were to use that as a benchmark, we would have real problems, because there was a study done by Tim Aubry from the University of Ottawa that showed that the service range to keep homeless people housed, out of the justice system and out of emergency units actually cost an average of \$6,000 a year. So that's where you have a research-established benchmark, and that's why things like the systems enhancement evaluation initiative are so important: because they can actually give you those benchmarks that you're not going to get out of a data system.

There also needs to be a mechanism to monitor progress for 10 years at least, in co-operation with service users, families, LHINs and health service providers. This is so critical, because if you don't have something like that, there is no way of keeping governments' or LHINs' or service providers' feet to the fire.

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As experience shows, in Italy, for example, it has been 30 years since they passed a law to close down their large institutions and build a community-focused system. They've had uneven progress across the country, but there have been parts of the country where stakeholders were really focused on making sure the reform happened, like Trieste. There, you have 94% of the money being spent in the community and the lowest rate of involuntary hospitalization in the country. They send very few people into the forensic system. So this can be done, but you do need a mechanism to keep people's feet to the fire.

There also have to be strategies focused on mental health promotion and well-being and, as I said before, strategies to reduce poverty among people living with mental illness. That includes dealing with ODSP and OW rates, and it also includes helping people with employment.

Also, I think Ontario has a tremendous opportunity to use the work of Canada's mental health commission. At the end of this month, there'll be a new set of goals enunciated by the commission that are the result of a year of consultation. I think you can also contribute to the work.

As a policy initiative, I would suggest that the mental health share of health spending must be at least 10% by 2019, but there are 10 years to get there and hopefully the recession won't last that long.

The final thing is: Believe that we can actually make some progress.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Steve. You've left about 30 seconds for questions, so I'm going to steal that.

We've had a number of presentations, and some of them would be termed as "qualitative presentations," where it's the right thing to do, to get better at this. Yours had a lot of quantitative analysis, where it's not just the right thing to do; it's the smart thing to do. You're saying, "If you invest in mental health"—I think the ratio is \$1 to \$7 in your presentation.

From a cold, clinical, business perspective, what is the payback period of a sizable investment in mental health? When would you start to see your jail costs come down? When would you start to see the justice costs, the hospital stays and the other things outlined come down? Has anyone done any work in that regard?

Mr. Steve Lurie: In fact, I can cite two pieces of evidence that already exist. For example, with the assertive community treatment team initiative, what we were able to show is, within one year for people who access ACT teams—it took a year or so to get them set up, but there was a 23% reduction in hospital days. At the end of six years, there's an 82% reduction. So if you think of two to five years, you would begin to see those payoffs.

The SEEI that I spoke of earlier showed that on the one hand, while more people were brought to emergency, which would seem to be a problem, the hospitalization rate actually went down because the right services were in place in the community.

I would certainly suggest that with housing, if you can provide stable housing for people, you'll see huge benefits immediately.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today.

ONTARIO HOSPITAL ASSOCIATION

The Chair (Mr. Kevin Daniel Flynn): Our final presenter of the day is the Ontario Hospital Association. We've got Tom Closson and Glenna Raymond. If you'd like to come forward. Make yourselves comfortable. You have 15 minutes to use any way you see fit. If there's any

time at the end, I promise not to steal it. I'll try to share it amongst the group this time.

Mr. Tom Closson: You'll share it. Good afternoon. My name is Tom Closson. I'm the president and chief executive officer of the Ontario Hospital Association. With me today is Glenna Raymond. Glenna is the president and CEO of Ontario Shores Centre for Mental Health Sciences in Whitby.

The Ontario Hospital Association is a voluntary organization representing approximately 155 public hospital corporations throughout Ontario. Over 70 of our hospital corporations have in-patient units for people with mental illness, and all of our hospitals, all 155 of them, serve people with mental health and addiction needs in some way or another.

Recently, the Ontario Hospital Association provided input to the Minister of Health and Long-Term Care's draft 10-year mental health and addictions strategy. Today we're really pleased to have an opportunity to present to you, the members of this committee.

At the outset, I would like to stress one key thing: We're not here to request additional resources for hospitals. Rather, we're here to talk about the great potential for success in concentrating existing resources throughout the Ontario health care system on a high number of high-impact areas. Rather than taking a broad approach to mental health, which is a complex issue, we believe it's important to use an evidence-based, targeted approach to try and have impact on what can be achieved for people with mental health and addiction problems. Our recommendations today align with the Ministry of Health priorities that have already been stated by the ministry in terms of trying to transform the health care system, their two key priorities being reducing emergency room wait times and improving access to care.

It's our goal to work closely with legislators to identify and deliver practical solutions for improving the broader health care system. So with this view, these are our recommendations. I'm going to start this off with the first two and then pass this on to Glenna for the others.

The first recommendation is to reduce emergency room wait times by enhancing mental health and addictions service delivery. Achieving this would require acute care hospitals and community organizations to work together to develop non-emergency services that are coordinated, standardized and measurable. Many people experiencing mental health and addiction issues don't seek treatment at all, while others seek care in emergency rooms only at times of crisis. It is often because there are few or no alternatives available in the community. Recognizing that not one solution fits all communities, expanding the range and availability of alternative services would help ensure that emergency care is available for patients who truly need it, the goal being to minimize the number of people who actually go to emergency departments in crisis.

There are two possible solutions that we're suggesting in a concrete sense. One is developing a 24-hour, seven-day-a-week, community-based crisis response system.

With direct links to hospitals, this model would be able to meet an individual's need for crisis stabilization outside of the hospital.

The other is placing a community-based discharge worker in a hospital with links to case management, housing etc. This would help ensure continuity of care while diverting patients away from the emergency room and facilitating earlier discharge to the community if a patient ends up being admitted.

The second recommendation is to improve access to care by strengthening mental health care and addiction clinical capacity in the community. Strengthening mental health clinical capacity within the community ensures that individuals seeking mental health and addiction care receive the most appropriate care where and when they need it. Two possible initiatives are suggested here.

The first is expanding family health teams, nurse practitioner clinics and community mental health centres in an organized way in order to increase access to primary care services for people with mental health and addiction needs.

The other is improving the mental health care and addiction knowledge and expertise of the multidisciplinary health care professionals who work in these primary care clinics. Ensuring that appropriate training and supports are in place for these practitioners will assist in early intervention and screening and create safe and supportive environments for people seeking treatment.

So far, I've outlined two of the five recommendations we're presenting to you today. I'm now going to pass it over to Glenna, as I said. At the Ontario Hospital Association we have a mental health and addiction provincial leadership council which advises me, as the CEO. Glenna is the chair of that council and she's also a great ambassador for mental health and addiction patients throughout Ontario; so Glenna will address the remaining recommendations.

Ms. Glenna Raymond: Good afternoon, everyone.

Our third recommendation is that a central leadership structure and accountability framework be created to support mental health and addiction issues. We're all quite familiar in Ontario with Cancer Care Ontario and the tremendously positive impact that it has had as a provincial agency, improving direct cancer services across the province. Similarly, a second example: A provincial approach is being utilized in support of the diabetes strategy. These are great examples of how we should be treating mental health and addiction care, and as such, we strongly endorse a similar province-wide approach to the delivery of mental health and addiction services. This approach would promote equitable access, accountability, standardization of care, delivery of evidence-based practices, quality measures and provincial coordination of resources.

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Our fourth recommendation is to focus more strongly on interministerial collaboration. Within the mental health and addictions sector, there are subspecialty populations such as children's needs, seniors, forensic clients,

the homeless, and those individuals living in rural and remote communities, among others, whose care and treatment are the responsibility of a number of different ministries. Interministerial collaboration would ensure that services are planned and delivered in a coherent and equitable fashion, and ensure that individuals have the range of services that is really essential for recovery, whether that's housing, employment, education or community services.

Currently, some clients in rural and remote communities face real difficulties in accessing specialized inpatient mental health and addiction services, as well as the community supports. These patients not only require improved access to care, but transportation options, such as the use of the northern health travel grant program; they require affordable housing; and also for our professionals working in the field, workplace strategies to ensure recruitment and retention. Strengthening interministerial collaboration will help ensure that these subspecialty populations receive the most appropriate care required.

Our fifth and final recommendation we want to focus on today is related to research and development. Many do not consider the economic imperative of investing in mental health and addictions. In 2007-08, the government of Canada, through the Canadian Institutes of Health Research, invested \$65.9 million in mental health and addictions, although it's estimated that mental health problems cost the economy \$33 billion per year in lost productivity. Furthermore, the presence of co-morbid conditions and high mortality rates among the mental health population has been very well-documented. As such, we believe that investments in mental health research and related biomedical research are greatly needed.

While we strongly support the work of the Mental Health Commission at the national level for their endorsement of a broad vision of mental health research, they too have expressed concern that adequate resources are not being devoted to mental illness and addiction, especially given the social and economic burden on Canadian society.

We encourage government to support academic and specialty mental health hospitals in leading the creation of research capacity in developing and then disseminating best practices.

In closing, I'd like to reiterate our enthusiasm for the commitment that government has shown in helping those Ontarians and their families who cope with mental health and addictions every day. Thank you for the opportunity to speak with you. We welcome any questions that you may have.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Glenna. Thank you, Tom. I think we've got time for one question each, starting with France.

M^{me} France G  linas: Thank you so much for coming to present. I'm most interested in your recommendation number three, which is creating a central leadership structure to support mental health and addiction. The field of addiction is very different from cancer, which is

mainly with oncologists in hospitals; with mental health, you're talking about over 400 children's mental health agencies and over 330 community mental health agencies, not to mention hospitals, doctors' offices and everything else. Did you think it through and can you talk about this a bit more?

Mr. Tom Closson: Maybe I'll start. The point we're trying to make here is, even though regionalization makes a lot of sense in terms of trying to integrate service at the ground level, you need central leadership on: What are the best practices that we're going to implement? What are the, say, six key things that we want to implement over the next few years that are really going to make a difference? Somebody needs to be driving this from the centre, based on evidence.

Right now, we have nothing in terms of central leadership around mental health in the province. Cancer Care Ontario was just used as an example where we've had very strong central leadership over quite a few years. I used to work in British Columbia; British Columbia used to have a much better cancer system than Ontario, and that was because they had strong central leadership on the full range of services. Ontario, in my opinion, based on the data, has caught up. That's because, over the past particularly five to seven years, there has been a much stronger central focus across the continuum of cancer care.

So we're not saying how to actually organize this, but we do think the concept of central leadership is essential.

M^{me} France G  linas: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Any questions? Liz?

Mrs. Liz Sandals: I find the concept intriguing because one of the things that Cancer Care Ontario did, I think, was establish what needed to be available in tertiary care and what needed to be available in secondary acute-care hospitals around each region.

Do you see that same sort of thing, then, in mental health, where somebody would be saying, "These are the services that need to be available in each community or each LHIN," and then having a focused way of looking at: "Are those services available and, if not, how do we make sure they're there?"

Ms. Glenna Raymond: There's very much an approach to define where the best setting is or the most appropriate setting for various communities, knowing, of course, that each community might be slightly different: the standards of care, the roles of various providers, the measurement tools, the accountability framework to report back on those and setting that in motion.

The central authority or central coordination that we're suggesting would not be, by any stretch, the provider of all services. It's quite different than providing the service.

Mrs. Liz Sandals: But it's identifying what the service is, what the benchmarks are and what the standard of care is so you've got a consistent vision across the province.

Ms. Glenna Raymond: And how they are connected.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Glenna, Christine?

Mrs. Christine Elliott: Thank you very much for your presentation. I just have a quick question regarding the research piece. Generally speaking, I think the research issue has been seen to be more at a federal level than at a provincial level. But if I could just clarify, are you speaking more about working on best practices in hospitals and funding some of the projects more locally in local settings? Is that your vision? Maybe you could speak a bit about that.

Ms. Glenna Raymond: Sure. There's room for two directions in research: one, which you suggested, is best practices—the dissemination of that—and the research of treatment modalities. More applied research at a local

level is definitely needed. As well, though, the role that we see of academic health providers in other diseases—we need to see more of that in mental health, from the academic mental health science centres and the specialty areas, whether it's biomedical research, cures or treatments. That's a second focus or a second direction for research that's needed, and we lag way behind other illnesses. In that way, we're discriminating against those with mental illness.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today. Thank you very much for your presentation.

To the members of the committee, thanks for your attendance today. We're adjourned.

The committee adjourned at 1805.

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Journal des débats (Hansard)

Mercredi 21 octobre 2009



Select Committee on Mental Health and Addictions

**Mental Health
and Addictions Strategy**

Comité spécial de la santé mentale et des dépendances

**Stratégie sur la santé mentale et
les dépendances**

Chair: Kevin Daniel Flynn
Clerk: Susan Sourial

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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

SELECT COMMITTEE ON
MENTAL HEALTH AND ADDICTIONSCOMITÉ SPÉCIAL DE LA SANTÉ
MENTALE ET DES DÉPENDANCES

Wednesday 21 October 2009

Mercredi 21 octobre 2009

*The committee met at 1605 in committee room 1.*MENTAL HEALTH
AND ADDICTIONS STRATEGY
SIMONE USSELMAN-TOD

The Chair (Mr. Kevin Daniel Flynn): Okay, ladies and gentlemen, if we can call to order this meeting of the Select Committee on Mental Health and Addictions.

Our first delegation today, at 4 o'clock, is Simone Usselman-Tod. Simone, if you'd come forward. Make yourself comfortable. Use any one of the microphones you'd like. There should be some clean glasses there with the water.

You're our first delegation of the day, so I'll just explain the rules a little bit; they're not complex at all. You get 15 minutes. You can use that any way you see fit. It's always better if you leave a little bit of time at the end, if you're able to, for any questions and answers that the committee may have, but that's entirely up to you. Please feel free to sit. Other than that, the time is all yours.

Ms. Simone Usselman-Tod: Thank you very much, and good afternoon. I want to say thank you for making the effort to address addictions and mental health care in Ontario. Thank you for giving me the opportunity to speak on a topic I feel so strongly about, and which has been a significant part of my life for the last five years.

My name is Simone. I am an X-ray technologist and a registered massage therapist, and I run an equine boarding facility for 27 horses. I am a wife and, most important of all, I am a mother of two beautiful daughters, aged 17 and 19 years old, who I am pleased to say are both alive and well.

This is a success story about my youngest daughter. She did not have cancer, she did not have a heart defect and she did not have a blood disease. She was diagnosed with mental health disorders in the form of social anxiety, depression, eating disorder and self-harm issues, which escalated to substance abuse because we could not get her complex issues addressed here in Ontario.

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Katie started struggling with her mental health issues at 12 years of age, symptoms of which would be considered relatively normal or at least within the normal parameters of teenagers these days. During puberty she became withdrawn, had angry outbursts and had diffi-

culty dealing with transition. All could be blamed on hormones.

Her symptoms started subtly but increased in severity over three years until she was 15 years old and came very close to losing her life when her issues became life-threatening, a potential death sentence. "Death sentence?" Strong wording, you might say. It is a potential death sentence when appropriate care cannot be accessed. Our journey through the caverns of the mental health care system left us frustrated, scared, distraught, distressed, angry and hopeless. The toll on my daughter as well as her family is immeasurable.

She was assessed by our family doctor as well as four social workers and counsellors, and it was decided that she was dealing with depression. Of that we had no doubt. We were told she was a teenager and was experiencing depression, as if it was not a huge deal. Her behaviour fluctuated between withdrawn, angry, lashing out, swearing, belligerence, self-destructive, self-sabotaging behaviour, restricted eating and impulsivity—an extreme teenager, you might say, or a youth with mental health illness.

Her behaviour escalated over the next few months. Home life was stressful and filled with tension. I began getting calls from other parents, who were concerned about Katie's behaviour with her friends. She was scaring her friends because of talk about taking a bottle of medication, as well as cutting her wrists.

She became less social, more irritable, and intolerant of everything and everyone. We became suspicious of her interactions on the phone as well as the computer. It was a full-time job looking after her. Out of concern for her safety and for our peace of mind, we started taping any incoming and outgoing phone calls as well as her MSN use. Her behaviour was becoming more erratic and she became rude and obnoxious. Our home was a very unpleasant place to live. We had tried being stricter, talking about our concerns, and we were met with denial, anger and defiance.

We had seen four counsellors, whose suggestions ranged from getting firmer with her—we had difficulty physically getting her to school, which she absolutely refused to attend. It was suggested that we get more restrictive if necessary or cut her more slack, that we were to blame for her symptoms because of our upbringing and the way we dealt with her, and that we were being too fair. Needless to say, we were not bestowed with any kind of confidence.

Friends said to kick her out; she was an unruly teenager. What I saw was my child struggling severely emotionally, and she had developed a poor sense of judgment and was very disconnected. My child was ill. If she had brain cancer and her behaviour had changed because of the effects of the disease, I would not stop taking care of her. If she had broken her leg and was having difficulty doing the things she used to do, I would not kick her out. But now, because she was coping poorly and was negative, angry and threatening suicide, it did not mean I was going to desert her.

I knew she was ill, and on some level I knew there was more than depression going on but I could not identify it. It was not until she entered the US mental health care system, in desperation, that she was diagnosed with a severe generalized anxiety disorder. Our search for assistance within the mental health care system in Ontario was anything but successful.

As my daughter's symptoms continued to escalate, we became distraught at our inability to help to relieve her symptoms and became more desperate as she continued to cut the flesh on her wrists, forearms, abdomen and thighs with blades. We were told there was nothing we could do to make her stop. I was horrified that this beautiful child of mine was cutting her flesh and couldn't believe that there was nothing we could do to help our 13-year-old girl.

Her sleeves were often bloodied. She began to show others at school what she had been doing to her body. She was desperately asking for help and for someone to notice her pain. My daughter still carries these scars today. Not three or four—no, her left arm carries about 100 two-inch scars that can't be missed, a clear reminder of where she was mentally and emotionally just two and a half years ago.

As parents, we have had to deal with the pain, embarrassment and shame that go with the stigma of cutting and mental health disorders. I work in the medical field. I know what others will assume about my daughter's judgment and her perspective: fear, horror, disgust and recoil. I know; I have felt the same way when working with patients with multiple self-inflicted wounds and scars.

All approaches we had taken with the Ontario mental health care system had been relatively unsuccessful. Treatment through our family doctor and counselling did not relieve my daughter of her endless pain. The disassociation resulting from cutting her skin did not give her enough relief from her emotional pain.

Katie deteriorated and became more and more desperate. We could find no way to offer her relief. She had constant headaches, was too tired to get up and was not hungry. She became thin and more anti-social. We felt we were at a wall. Then, almost overnight, there was a sudden change in her mood. In fact, she was actually pleasant, with fewer intervals of obnoxious behaviour, and we were offered some relief. Then we started to notice money going missing. Horrified, we realized she was probably using some sort of drug to relieve her dis-

comfort. We searched her room and came up with ecstasy pills. With this, she ran away from home and we could not find her for over 24 hours. I realized at this point we could no longer keep her safe; in fact, she may not survive this ordeal.

Pictures in my head of all the addicted and overdosed patients who I'd seen over the last 25 years in emergency at the hospital came to mind, as well as those who left emergency for the last time in a body bag. "My God," I thought, "We may have lost her for good. What if there was something else we could have done? What if she doesn't survive? We may never see her make her 15th birthday. What if my child is dead?" Do you know what it's like to have to come to terms with the fact that your child may die or be dead because you couldn't get help for her? Talk about the ultimate failure as a parent: How could I ever live with myself? I felt completely lost and defeated. My daughter started with a mental health disorder and had ended up with an addiction.

What is a concurrent disorder? Concurrent disorders describe a situation in which a person experiences psychiatric disorder and a substance use disorder or addiction. It is important to keep in mind that there are many different kinds of problems that are covered by these various terms. As a result, concurrent disorders present themselves in many different forms. For example, someone living with schizophrenia or depression who has problems with cannabis use has a concurrent disorder, and so does a person who has problems with alcohol use and has clinical depression.

In my daughter's case, her concurrent disorders were complex. She was diagnosed with more than one mental health disorder, being an eating disorder in the form of anorexia nervosa, as well as clinical depression, generalized anxiety disorder and self-harm. The other part of the concurrent piece was substance abuse in the form of alcohol, ecstasy, ketamine and cocaine. She was 15 years old.

Her multiple issues limited access to appropriate care. For instance, addressing the eating disorder was frustrating. Her multiple issues restricted her from being accepted into the eating disorder clinic at McMaster Hospital. If she just had an eating disorder she would have been accepted into the program. Instead, we were turned away because she did not meet the limitations of the criteria set for the program. It was felt that if her eating disorder was addressed it would cause other issues to escalate. There was no comprehensive care available at one location to address her multiple needs. Her complex combination of disorders didn't fall within the parameters of services within Ontario.

Foremost, I am a mother, as many women are. I also have the advantage of working in the medical field in a children's hospital in Hamilton. I have connections and I'm not afraid to ask for help. I am educated, I speak English, and my father is a doctor. I could not navigate the Ontario mental health care system for my daughter. How on earth can someone who does not have my background, is not educated and who does not speak English ever hope to do so?

By chance, my sister found a place called Recovery Counselling Services in Toronto. I have some information in the package that I handed out. Recovery Counselling Services saved my daughter's life. After my first conversation with the intake counsellor, I felt there was actually some sort of glimmer of hope, perhaps a slight possibility that my daughter might have a chance—maybe. We were coached on how to encourage her to come for a meeting with one of the counsellors and for the first time we actually felt support in our quest to help our daughter. After three counselling sessions, Katie agreed to attending residential treatment. The recommendation was at Caron in Pennsylvania, as there were no residential treatments available here in Ontario for the severity of the problems Katie was facing, as well as her age issues. From this point on, we have never looked back. My daughter spent 10 months in residential treatment and then 10 months in a transitional program in Utah, where treatment is comprehensive and continuity of care is a priority, amongst many other aspects.

After 20 months at Vista Treatment Center, Katie returned home in January 2009, just before her 17th birthday. She is currently attending an outpatient program in Toronto, Ontario, Recovery Counselling Services, a private business which involves three hours of commuting. She also sees a psychiatrist in Toronto once every six to eight weeks for medication assessment. Katie has been home for nine months, properly medicated to address her mental health issues, and has learned many techniques to help her cope on a day-to-day basis. She has not relapsed and is doing well. When my daughter said "Thank you, Mom. Thank you for saving my life," I cried and cried with tears of joy.

Again, this is our success story. My daughter is alive and well today.

Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Simone. You've left a few minutes for questions, starting with Sylvia or Christine.

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Mrs. Christine Elliott: Thank you very much for your presentation today, and I'm glad you had a happy ending, but it sounds like it was a huge struggle to get there. You mentioned that your daughter was not able to get into an eating disorders clinic because she had such multiple problems. Is that something that you would recommend, that we have a more comprehensive system? And is that the nature of the programs that you entered into in the US? Is that what made the difference for you?

Ms. Simone Usselman-Tod: Absolutely. It was the ticket. The problem that I find in Ontario—it's like if you want to make a sandwich: you have to go to one place for the bread, somewhere else for the mayonnaise, somewhere else for the mustard, somewhere else for the turkey, somewhere else for the lettuce and somewhere else for the tomatoes. If you don't hit all those places, you don't have a sandwich. And here—you know what?—the piece of lettuce wouldn't have cut it. Most kids with concurrent disorders have one mental health issue with substance abuse; she had multiple.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Simone. Michael?

Mr. Michael Prue: I want to just follow along on that. This is a real hard struggle; I realize how difficult this is for you to talk about this. Are there other parent groups or people with whom you can talk? Is this recurrent, or is this just something that happened to your family because of the multiple disorders?

Ms. Simone Usselman-Tod: This is recurrent. My daughter attends a support group with Recovery Counselling Services, which I have listed in the papers there. For two years, I attended parent group meetings, and it was not uncommon. I think a lot of people get lost in the system. I was very fortunate to find Recovery Counselling.

Mr. Michael Prue: And did they all have to go the States?

Ms. Simone Usselman-Tod: Not all of them, no, not necessarily.

Mr. Michael Prue: But some?

Ms. Simone Usselman-Tod: It depended on the use and the risk of the youth. My daughter was at very high risk. Her use, as far as substance abuse, went from nothing to pretty much all day within three months.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Simone. Liz?

Mrs. Liz Sandals: I'm just trying to sort out in my own head here what Caron did, and what role Vista played, because if I understood you, she was at both and they're, given the addresses, obviously two quite different programs.

Ms. Simone Usselman-Tod: Right. Caron is a primary care. She spent a month in that program, and then they're assessed and they move on to either a longer-term process within Caron or another facility. It was deemed, through a lot of discussion, that Vista Treatment Centers was a more appropriate system for her; it was potentially more long term and her issues were complicated. She went to residential treatment at Vista Treatment Centers for 10 months, and then we explored a transitional program, which is not available in Ontario. We have either residential or outpatient; we don't seem to have anything in between. They provide a transitional program so that she can be worked at a level system to be more integrated into the community again. Since she's been in the outpatient program here in Ontario, she has done very well.

Mrs. Liz Sandals: So was she in a transitional—partly in-patient, partly outpatient—in the US, or is it that Vista organized transitional support here?

Ms. Simone Usselman-Tod: No, transitional support is in Utah, at Vista. What happens is they start with a lot of fairly high monitoring, especially as a transition from the residential program into the transitional program, because the transitions are hard for them anyway. As they prove themselves to be more responsible, they have more and more freedom and choice. So it's an earned program. It worked very well for my daughter. If I gave my daughter the choice of harm reduction and, "It would

be nice if you stayed clean," I would have lost her. She's a high-risk teen; she's not going to take "maybe." "Maybe" means "I'm not taking part in it."

Mrs. Liz Sandals: Thank you very much for helping us sort that out.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Simone. I have a short question. I visited Caron about a year ago because it seemed that a lot of kids in my constituency were ending up down in Caron, and I was quite impressed with the facility. Where there seemed to be a shortfall, and you may have addressed it—had your daughter come home from the treatment she received in the States and had to rely on the public system to get aftercare, would she have gotten it?

Ms. Simone Usselman-Tod: Not adequately.

The Chair (Mr. Kevin Daniel Flynn): Not adequately, so it probably would have all fallen apart?

Ms. Simone Usselman-Tod: I was not willing to risk that.

The Chair (Mr. Kevin Daniel Flynn): Was Father Bill at Caron when she went down there?

Ms. Simone Usselman-Tod: Yes he was.

The Chair (Mr. Kevin Daniel Flynn): He's quite a character.

Ms. Simone Usselman-Tod: He's amazing. I'm very impressed with the system down in the States, and what I've left you too is, they've got a system that works there. Basically, in Ontario we have a harm reduction system; they use an abstinence system.

The other issue is age. At 16, if a youth wants to walk out here, they can; they have to be 18 in Utah, which gives you an extra two years to work with. Interestingly enough, my daughter chose to stay in the transitional program for the whole 10 months. She was very interested in becoming clean.

The Chair (Mr. Kevin Daniel Flynn): Okay. Did you go down for one of the Sunday morning services?

Ms. Simone Usselman-Tod: Oh, yeah. I was down every month with my daughter, and we went down for the three-day education program that they had for the parents there. It was fabulous—priceless.

The Chair (Mr. Kevin Daniel Flynn): Great. Well, thank you very much for coming today and telling your story. It certainly is appreciated.

Ms. Simone Usselman-Tod: Thank you. I've also left my contact information in the paperwork that I gave you. If there's anything else I can do to help the system—I'm also in discussion with the Ontario government right now about funding transitional programs down in Utah. I'm happy to add anything else I can at a later date.

The Chair (Mr. Kevin Daniel Flynn): Perfect.

Ms. Simone Usselman-Tod: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today.

ELEANOR BAKER

The Chair (Mr. Kevin Daniel Flynn): Okay, our next speaker after Simone is Eleanor Baker. Eleanor, if

you'd like to come forward and make yourself comfortable. You were here when I explained the rules—

Ms. Eleanor Baker: Yes.

The Chair (Mr. Kevin Daniel Flynn): —so I don't have to explain them over again. It's all yours. Just relax, pour yourself some water if you'd like, and I'll get the clock going.

Ms. Eleanor Baker: Thank you. My name is Eleanor Baker, and I am the mother of a young man with a serious persistent mental illness. He was diagnosed with schizoaffective disorder in 2000, when he was 17 years old.

Feelings of anxiety, stress, guilt, shame, self-blame, fear and anger are often experienced when a family member learns they have a loved one afflicted by mental illness. Life becomes chaotic and unpredictable.

My son had learning disabilities which were identified when he was in grade 1. He always struggled in school and was in special education classes. He was not well integrated in our community schools.

He was seeing an adolescent psychiatrist in the community for motivational counselling, so he was already in the system. Even then, it was so very difficult to get him much-needed help. He was becoming increasingly depressed and was hardly sleeping.

Things were getting much worse at home. He was becoming increasingly agitated, hostile, had marked distortions in his thinking, disturbances in his behaviour and was beginning to experience hallucinations, which were terrifying for him. He was non-compliant with his appointments as well as his medications.

It was after my husband developed a serious cardiac condition that it was recognized that things needed to be done quickly, and a referral was made to the First Episode clinic at CAMH.

Once he was diagnosed, there were still significant issues in commencing the necessary treatment he so desperately required. He was psychotic and didn't believe he was ill, and consequently refused treatment. People who are psychotic often have no insight and are trapped by their illness. They can be allowed to avoid essential care, which may result in lengthy treatment delays. These individuals frequently do not want their family involved. If this is the case, it should not be assumed that the family is not in need of support and education.

He requested that his case be heard by the Consent and Capacity Review Board where I gave testimony. This was the hardest thing that I had ever had to do. I did not want him to be hospitalized and formed, but he urgently required medical treatment to begin on his road to recovery, and I became his substitute decision-maker. This experience demonstrates the importance of having families actively involved as partners in care to provide vital information when critical treatment decisions are being made.

When he was discharged home six weeks later, and my husband was recovering from cardiac surgery at the same time, I realized that I desperately needed support. I

required this so I could cope and subsequently support my son in his recovery. I didn't know where to turn and was shocked by how cumbersome this process was.

His case manager felt that it was a conflict of interest to provide support to me, because my son felt that he was well and everything would be fine as long as the mental health system and everybody in it would just simply leave him alone.

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After many attempts and multiple inquiries, things finally turned around. I was invited to participate in a focus group which was sponsored by the First Episode clinic at CAMH, to develop and design a community-based program for early intervention clients. Here we discussed the enormous need for family support and education. A family support group was started for First Episodes in Psychosis family members at CAMH. At one of these sessions, a family volunteer from the Schizophrenia Society of Ontario spoke, and I became a member of the organization the following day.

SSO has truly been my lifeline over the last several years. SSO strives to improve the quality of life for those affected by schizophrenia and psychosis through education, support programs, public policy and research. They also work co-operatively with organizations for allied disorders. They support, educate, engage and empower families.

Advocating on behalf of people affected by schizophrenia is an important part of SSO's work. The number of people in the justice system with mental health and addiction issues is increasing annually. The justice and mental health program was developed at SSO a few years ago to support the families of people with mental illness who have come in contact with the law, while promoting change in mental health and justice.

My son was admitted to CAMH once again three years ago, after he stopped taking his medications and became ill once again. He was formed, his case was taken to the Consent and Capacity Review Board, and once again I testified. He was in hospital for three months, until he was stabilized. He now continues to be compliant and is presently taking a college-level course once a week.

Last year he had the best three months since he became ill, when he had a job placement at a bank. This was the result of vocational support, which is an imperative part of the recovery process. Unfortunately, this placement came to an end because he was no longer able to work when he developed involuntary movements due to side effects of his medication.

I now dedicate a fair bit of time to volunteering, helping other families and also providing a voice for families in the mental health and addictions system. I am actively involved in family education programs and facilitate peer support groups for families at the Schizophrenia Society of Ontario. I am co-chair of the Toronto region chapter leadership committee of SSO.

I am a family member on the Ontario Working Group for Early Psychosis Intervention. The group is made up

of individuals and organizations that share the goal of developing an effective treatment and support system for the early stages of psychosis. The working group is focused on bringing the benefits of early treatment to all citizens of Ontario who experience the onset of psychosis, and on providing support to their families.

I am also a member of the Toronto Central LHIN mental health and addictions family advisory working group, as well as the family member on the Toronto Central LHIN mental health and addictions steering committee.

I do this work because, as a result of my experiences, I firmly believe that it is of vital importance to have families involved as partners in care. I am providing two documents for all of you which support this.

I would like to mention some of the things that I feel should be included in Ontario's provincial mental health and addictions strategy.

There needs to be in-service training in all levels of the school system so that teachers and auxiliary staff can recognize when a student has a mental health issue, and they know when and how to communicate this very sensitive subject to families.

There should be more in-service training in mental health and addiction for family physicians and pediatricians so they can make referrals to first-episode programs or other appropriate programs in a timely manner.

There should be trained professionals, specializing in family work, to work with families to support them through all phases of the illness. Supports for the family, as well as for the client, change in focus as recovery progresses. Structured family support should be incorporated into the recovery plan of the individual from the beginning, and it should become a formalized component of working with clients who have a mental health and addiction issue.

The needs of francophone, aboriginal, and ethnic minorities must be considered and supported.

There is an urgent need for increased support to family and consumer organizations. Existing and new consumer and family organizations require funding at an annual and sustainable level.

I would like to sincerely thank all of the committee members for your dedication and hard work in the process of improving the mental health and addictions strategy in Ontario for all of its citizens, and for the opportunity of speaking to you today.

The Chair (Mr. Kevin Daniel Flynn): That's great, Eleanor. Thank you very much. You've left lots of time for questions. Michael, do you have a short one?

Mr. Michael Prue: I'm sorry, I didn't have a chance—I apologize. I just came in, so I'll pass it to my colleagues.

The Chair (Mr. Kevin Daniel Flynn): Anybody on this side have a question? Helena?

Ms. Helena Jaczek: Thank you very much. I think you've really summarized very well for us what we've been hearing over and over again. The issue you described around early recognition I think we're very

conscious of; also, the fact that family doctors quite often don't have the expertise to assist and recognize and make appropriate referrals and so on. We've also heard a lot about housing and that kind of issue, as well as the job and vocational training.

I may have missed it, but could you describe what's happening with your son at this point?

Ms. Eleanor Baker: My son lives in our home. He's 26 and he is living with us.

Ms. Helena Jaczek: So this is something you haven't had to face—

Ms. Eleanor Baker: I haven't, and that was the main reason why I didn't address it, although I do have a great deal of knowledge of this from the families that we've spoken to at SSO and through my work on the Toronto Central LHIN.

Ms. Helena Jaczek: And do you have any particular recommendations around what type of housing or—

Ms. Eleanor Baker: More affordable housing units that have support for these types of individuals.

Ms. Helena Jaczek: Peer support—have you had any experience there?

Ms. Eleanor Baker: Peer support, yes. Actually, I do—well, peer-family support, and there is peer support also that is being done now for consumers at the Schizophrenia Society of Ontario.

The Chair (Mr. Kevin Daniel Flynn): Christine or Sylvia?

Ms. Sylvia Jones: Thank you, Eleanor. You made reference to vocational support. It's not an area that we have talked a great deal about or had a lot of presentations on. I wonder if you could expand on who was doing that vocational support with your son and how the process went.

Ms. Eleanor Baker: My son's case manager that he's now seeing because he's no longer first episode. He's now being seen at a continuing-care facility, Spectrum, out on the Danforth, which is under CAMH's umbrella.

But there is also a lot of vocational work that is being done by LEARN. I'm not sure if you're familiar with LEARN. It's also part of CAMH. It's located on St. Clair Avenue West at Oakwood. They deal with education and advocacy, and students who have not been able to finish high school have the opportunity to do so there.

When there isn't vocational support, my son would go for jobs and would get hired, but what constantly would happen is he could be easily distracted and he would be let go because it was often said that he was too slow. This was devastating. It makes things even worse and it makes it so difficult to move on with recovery.

When I mentioned those three months that he was at the bank—the other thing is, sorry to backtrack, a lot of these jobs for these young people are very menial tasks. When he was at the bank, his self-esteem was just right up there. He was respected there and he felt so good and told all our friends and family that he was working for the bank. It's the best he has been.

Ms. Sylvia Jones: So the vocational support was through CAMH?

Ms. Eleanor Baker: Yes.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Eleanor. Christine, a brief question?

Mrs. Christine Elliott: Thank you very much for being here today and for the terrific advocacy and volunteer work that you do. It's very time-consuming and obviously you've got a real passion for it.

If you could comment a little bit more on your experience with the Consent and Capacity Board, we have been hearing from a lot of parents about the problems that they have in accessing treatment for their children in situations where their children actively don't recognize that they're ill and don't want to be treated. You mentioned that you became your son's substitute decision-maker. My understanding is that's a very difficult thing to achieve. Could you maybe comment on how that process was for you?

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Ms. Eleanor Baker: The reason why this was done is because the form was upheld. He was actively psychotic at the time. I didn't want to testify but I was encouraged to do so because it would help to get him the treatment that he needed. As I said before, it was the most difficult thing, as a mother, I've had to do.

Because the form was upheld, and my husband was ill at the time, I became the substitute decision-maker and treatment was commenced.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Eleanor. Thank you very much for coming today.

FRONTLINE PARTNERS WITH YOUTH NETWORK

The Chair (Mr. Kevin Daniel Flynn): Our next delegation this afternoon is Frontline Partners with Youth Network. Is Jenny Katz with us? Make yourself comfortable, Jenny, and introduce your colleague.

Ms. Jenny Katz: Thank you. I'm here with Neemarie Alam, who is also from Frontline Partners with Youth Network.

The Chair (Mr. Kevin Daniel Flynn): Wonderful. Make yourself at home there. You have 15 minutes, like everybody else. Use that any way you see fit. If there's any time at the end, we'll see if we can share it amongst everybody.

Ms. Jenny Katz: Thank you. I think we're kind of hoping for a bit of a conversation, actually, so I can speak at length but I'm going to try not to and really invite questions and discussion.

I believe we're bringing a perspective that you might not have heard before. I'm here today, and I don't know if Neemarie might—she'll jump in at any point. We're used to interrupting each other.

I'm here today because I could not be here if something like this was happening two years ago. I was an employee at a children's mental health centre. In fact, I've worked at a lot of different children's mental health centres, as well as—oh, am I too loud?

The Chair (Mr. Kevin Daniel Flynn): When you get too close to the microphones, they tend to feed back. Just stay about a foot away and you'll be great.

Ms. Jenny Katz: Okay. The reason why I can be here today is because I quit my job. I quit my job because I wanted to be able to do a level of speaking that I wasn't able to do when I was employed in the systems.

There are a lot of front-line workers who have excellent things to say about how things could be changed, but they're not able to speak for fear of losing their jobs. These are front-line workers working in all different kinds of organizations, including a lot of provincial transfer payment organizations.

That is partially why I want to leave a lot of time for discussions, because we are going to bring a perspective that you might not otherwise have access to, because front-line workers cannot speak freely.

The reason why we started as a network is because we were losing so many young people to gun violence in Toronto. Front-line workers are dealing with grief and trauma and are losing young people that they're working with. Additionally, they're losing family members and community members, because front-line workers live in communities and work in communities as well.

Front-line workers, many of whom are dealing with their own historical trauma, their own current trauma and grief, aren't able to access support through their organizations and are starting to come together to meet with each other in order to get that kind of support.

But what has been recognized, in terms of getting that support, is that there are systemic issues that are contributing—oh, I keep moving closer and closer to the mike; I'm so excited—to violence and particularly youth violence in the GTA, and we're very concerned about that.

Our loyalty is generally with young people and families and communities, and sometimes we're asked to split our loyalty between our organizations and the communities that we're working in.

I invite you to look at our fancy handout that we brought. We got a little excited with text boxes.

I guess something that might illustrate some of the points that are in our paper is that for the last position that I held—and I just want to say that I was a clinical therapist. I went back to school and I became a clinical therapist working with young people who were mandated to see me through the court system for anger management issues.

These were young people who all had assault charges, and every single one of them had histories of trauma. Many of them had nowhere to live. And I was supposed to be doing anger management counselling with them.

I ended up focusing on working with young women with assault charges. Many of them were mothers. Many of them were soon to become mothers, I would later find out, but they were there to see me for anger management.

So there's a real disconnect, because what we know in best practice is that you do not treat trauma when people

are in the throes of it. People need stability and security in order to start looking at these things.

That put me in an ethical dilemma: Why am I doing anger management with young people who have every right to be angry? And the other question was—actually, I'm just going to ask Neemarie if she wants to jump in, because I know she probably does. Does she need this turned on in any way or does it—oh, it just happens magically.

Interjection.

Ms. Jenny Katz: You don't? Oh, okay. So I'll just keep talking.

The other issue that we were seeing was that the young people who were mandated to see us would never have otherwise entered the children's mental health system, yet all of them had had experiences of trauma.

The children's mental health system is—basically, if we look at a lot of the executive directors and senior management in these organizations, they're mostly white. In fact, they're almost all white in Toronto. But when we look at the young people who are coming in through the system, who are mandated to be there, they're often not. So the services are not reflecting the needs of the young people who are there, and are framing problems in a particular way that doesn't connect with a lot of young people and their families.

This brings us to the first page of our handout, which is "Stress, Trauma and Unequal Distribution of Wealth." I'm not sure about the other presentations that you've heard here, but the social determinants of health are a very useful way of understanding mental health and addictions. And there's growing research that shows if we do not address housing and access to good recreation, if we don't address education, if we don't address the unequal distribution of wealth, then we will see a growing number of young people in jails, in hospitals and in our children's mental health centres, which are really expensive, by the way.

I would encourage everybody to get behind any kind of poverty reduction strategies. I would also encourage people to learn about the social determinants of health.

I'm going to back up for a minute and quickly say who Frontline Partners with Youth Network is, because I got really excited and I realize that I didn't actually explain who we are. Frontline Partners with Youth Network is a network that is comprised of people working with youth across the city of Toronto. They don't represent their organizations; they represent themselves as people. There are over a thousand people involved in our network and they touch hundreds of families—well, actually, thousands of families. We interact with them through social networking websites, through our own website, through newsletters, through our listserv and through several activities. We offer free training that no one else will offer and we offer support that no one else will offer to front-line workers, recognizing that they are dealing with overwhelming stress and they can't necessarily do anything about it because their employers, who do their performance evaluations, can't hear about it.

I think I'm going to stop and see if there are any questions, based on all the stuff that I just said. There's a lot more but I'm just going to see if there is anything else.

The Chair (Mr. Kevin Daniel Flynn): Well, you've left about six minutes, so that's a couple of minutes for each party. Let's start on this side. Maria, Jeff, Helena, Bas? Anybody on the—Liz?

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Mrs. Liz Sandals: Yes, I'm curious about how the group that you've got—is it just an informal support group, or are you funded somehow? You said that you had quit your job as a front-line worker to work with the group. Are all of the people who work with the group in that situation, or are you the unusual leader?

Ms. Jenny Katz: I'm definitely an unusual leader. We work non-hierarchically. So, yes, I'm an unusual leader. Actually, Neemarie is the only other person who is working with us full-time. We have a lot of part-time workers; we're doing focus groups to look at male youth workers in particular, and their experiences around grief and trauma. We're using our informal networks to do that, but we do have a listserv of over 1,000 front-line workers whom we connect with regularly. We have some part-time staff and we have a number of volunteers. We have a stewardship group of front-line workers who represent the entire city.

I think Neemarie wants to add something to that.

Ms. Neemarie Alam: We're funded by CHEO through the provincial centre of excellence in mental health; we also receive Laidlaw funding and we've recently gotten a grant from the city of Toronto through their social development investment program to fund me to come on to support the infrastructure and capacity-building. So, similar to Jenny, I started out as a youth worker in a children's mental health agency and kept struggling because there was just so much work to be done. The expectation was that you'd be everybody for everybody all the time, and there was no support system to sustain that. It became so unsustainable that I had to leave, and I started here.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Sylvia or Christine?

Ms. Sylvia Jones: First a quick question and then a follow-up: You mentioned that you have about 1,000 workers in your network—

Ms. Neemarie Alam: Yes.

Ms. Sylvia Jones: Sorry, I may have missed it. Is it province-wide or GTA?

Ms. Jenny Katz: It's Toronto, and now we're expanding into Peel, although someone heard of us in Montreal, which was kind of odd. I'm also a part of the Sparrow Lake Alliance, which is a province-wide initiative. We sit at some policy tables trying to represent the truths of the front lines that don't otherwise get heard.

Ms. Sylvia Jones: I want to ask you more questions regarding the recommendation on the last page: "Develop a mechanism to engage with front-line workers from across sectors so that they safely share their knowledge

about what is and what is not working..." I'm interested in having a little more in-depth on that. It's something that comes up a lot with families in particular, particularly as they transition out of the post-18-year-old. Can you talk about how that recommendation came about?

Ms. Neemarie Alam: The recommendation, to my understanding of it, came about because youth work itself is really nebulous; it's kind of undefined, and there are these small subsectors that people are employed into, so it's arts or it's recreation or it's mental health. But what happens is, because you're working front-line and you develop these really strong, trusting relationships with young people, they come to you with more than just arts or recreation or mental health issues, and most organizations don't support their front-line workers supporting young people in accessing services in these other areas.

Ms. Sylvia Jones: But is that a privacy issue that they're running into or is it just, "We deal with this and we don't want to talk about anything more than what's in this box"?

Ms. Neemarie Alam: It's about trying to get as many referrals as possible; it's about just rotating people out as quickly as possible because it influences funding and it influences statistics. Unfortunately, our organizational systems are not set up to sustain trusting relationships with young people. So young people who have had this long history of not trusting people finally start to trust somebody who's a worker but can't utilize them completely for all the resources that they may be able to offer.

The Chair (Mr. Kevin Daniel Flynn): Thank you. France?

M^{me} France Gélinas: Do you see your model as something that could be repeated elsewhere?

Ms. Jenny Katz: Yes. In fact I've met with front-line workers from other sectors, particularly around the homeless sector, as well as people working with seniors and people working with small children. All front-line workers seem to feel like they're silenced when they want to talk about what's going wrong in the systems, and that they can't offer their truths because it will compromise the funding to their organizations. It's a massive problem.

Ms. Neemarie Alam: It translates to guilt and carries over.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today. Great presentation. You got a question from each of the parties in; wonderful.

Ms. Jenny Katz: Thank you, and our contact information is on the back.

Ms. Neemarie Alam: Thank you for having us.

The Chair (Mr. Kevin Daniel Flynn): Our pleasure.

FETAL ALCOHOL SPECTRUM DISORDERS STAKEHOLDERS FOR ONTARIO

The Chair (Mr. Kevin Daniel Flynn): Our next speaker today is from the Fetal Alcohol Spectrum Disorder Stakeholders for Ontario: Sheila Burns, the

chair, and Valerie Temple, the lead with the diagnostic working group. If you'd like to come forward, make yourselves comfortable. I think you were here at the start of the meeting, so you know what the rules are.

Ms. Sheila Burns: We do.

The Chair (Mr. Kevin Daniel Flynn): The time is all yours.

Ms. Sheila Burns: Hi. It's a pleasure to be here, and an honour to speak to the committee today to identify issues and opportunities that can address some of the systemic challenges associated with mental health and addictions in Ontario.

The Chair (Mr. Kevin Daniel Flynn): I'm assuming you're Sheila, are you?

Ms. Sheila Burns: I am. My name is on the next line.

The Chair (Mr. Kevin Daniel Flynn): If you would just identify yourself for Hansard, these folks have to get down everything you say, and then perhaps, Valerie, when you start speaking you could identify yourself too.

Dr. Valerie Temple: I will indeed.

Ms. Sheila Burns: My name is Sheila Burns, and I chair the FASD Stakeholders for Ontario, a volunteer collaborative of researchers, agency staff, specialists and parents who are advancing awareness regarding the needs of individuals with FASD and addressing the prevention issues for this neurological disorder. We focus on five areas, including diagnostic capacity, justice issues, prevention, intervention and support, and urban aboriginal. Our aim is to inform the government and the service sector about FASD so service provision can begin to more effectively accommodate those living with the disability.

Dr. Valerie Temple: Good afternoon. My name is Valerie Temple. I'm a psychologist. I'm also the co-lead on the Ontario stakeholders' diagnostic working group and I'm the clinical lead of the Surrey Place Centre adult diagnostic clinic. Our Surrey Place clinic is the first clinic in Ontario that's focusing specifically on diagnosis and intervention for adults.

I am aware that others have made presentations to the committee regarding FASD and its impact. I don't want to duplicate their presentations, but a quick recap: Fetal alcohol spectrum disorder is a disability caused by prenatal exposure to alcohol. Alcohol primarily impacts fetal brain development by causing cell death, dehydration and impairment in multiple areas of the brain. The degree of impairment depends on dosage, timing, and maternal and fetal factors. FASD occurs in 1% of the population, according to Health Canada, meaning it affects approximately 130,000 Ontarians.

You have heard that individuals with FASD are heavy users of services in Ontario, with high rates of mental illness, addictions, school failure, homelessness, unemployment, conflict with the law and having children they cannot care for.

The rates of failure are not intrinsic to the disability but reflect the absence of care that individuals require. Our lack of knowledge of FASD has not been benign. It has resulted in some of the trauma that underlies the

exceptionally poor outcomes. It is exacerbated by the fact that few, if any, services are set up to accommodate the addiction and mental health treatment needs of this highly vulnerable population. Yet there is no plan to address this underlying disability that implicates so many services in Ontario.

We know that there are high rates of mental illness in youth with FASD, and studies indicate that at least one quarter of youth in custody have the disability. Two studies, one cited to this committee by Judy Kay from Sioux Lookout, and another by the Children's Aid Society of Toronto, show that more than 50% of crown wards have FASD or prenatal alcohol exposure and the behaviour phenotype indicating the disability. These studies reflect other findings that indicate that 80% of children with FASD are not raised by their biological parents.

1700

This year's Ministry of Community and Youth Services' Results-based Plan Briefing Book shows that more than \$500 million were invested in mental health services, allocated to 260 agencies and 17 hospital programs. In spite of this investment, 25% of the children didn't show improved functioning at exit. The report also highlights recidivism rates for youth in trouble with the law. While there will be a review of practices, the current system offers 69% and 35% recidivism rates for youth in closed custody and community-based programs, respectively.

Without examining the role of brain-based impairments and problematic behaviour within these service delivery systems, we will invest funds in programs that are ineffective for at least one quarter of children and youth in crisis. I suggest that captured in the failure rates are the children with FASD. We are missing a critical opportunity in addressing the special needs of these troubled children. We are missing a vital opportunity to assess and then provide supports that can best meet their developmental, learning and social challenges. We are also failing to provide the information, training and support to adoptive, foster and kinship families.

You have heard from parents who have struggled to find the genesis of their children's challenges and then programs to meet their needs. You have heard from service providers who are struggling under the weight of growing demands for service and the need for funding. You have heard about small FASD initiatives that are trying to bridge the gap to bring information to community services so they are more effective.

We know that we can prevent some of the mental health issues, substance use and poor outcomes associated with FASD. Research indicates that outcomes significantly improve with six factors: early diagnosis, a stable and nurturing home life, not being a victim of abuse, absence of witnessing abuse, appropriate education and mental health services, and access to developmental services. These factors help define the next step, the action items needed by the province and our service delivery system to begin to address the needs of this

vulnerable group: individuals who make up a significant portion of the systems' users and clients, those whom the system is failing to serve in spite of the allocation of significant resources and the best intentions.

During discussions in the 1990s there was debate whether we should diagnose a disability for which there was no cure or treatment and one that implicated the mother so explicitly. By avoiding defining the problem, it would only grow, and no solution would ever be found. The Stakeholders has worked towards defining the problems and exploring solutions through the advancement of awareness, diagnosis, care support, and prevention of FASD.

Dr. Valerie Temple: I'm going to talk to you a little bit about diagnosis. Diagnosis of FASD is not a matter of a simple blood test or a CT scan, although these things might be part of the process. It's not like Down's syndrome, where there's a chromosomal abnormality that you can locate. Diagnosis of FASD requires a medical physical examination, a cognitive and skills assessment, and investigation of prenatal and medical and psychiatric history. It requires a team of clinicians, all with specialized training in FASD. In many regions of our province it's a great challenge to bring together the multi-disciplinary team necessary to make a diagnosis of FASD.

Diagnosis also takes a great deal of time, and the fact that there is no OHIP billing code for FASD diagnosis presents a significant challenge for physicians, as their time isn't recognized and it's not captured in the broader context of the medical system.

In addition to challenges, however, we also have opportunities—opportunities to recognize and utilize the resources already available to us across the province. Multi-disciplinary mental health teams do exist in many regions, and training these existing teams to identify and diagnose FASD would be a very valuable first step.

We're beginning to know what to do to address the complex needs of this significant subpopulation who are heavier users of the system, are at high risk of mental health and addictions and who have thus far had their needs unmet. We know that people with FASD often receive a variety of mental health diagnoses across their lifespan. Attention-deficit disorders, conduct disorders, borderline personality, post-traumatic stress and psychosis are a few of the very common ones.

Although there are effective treatments for these disorders through existing mental health systems, for people with FASD, treatment using traditional means is often ineffective. Clinicians working in this field will tell you that individuals with a brain injury such as FASD require specialized interventions and accommodations in order to be successful. Sending people with FASD, over and over, to traditional interventions leads to a sense of failure for the individual, frustration for the service provider and despair for the family. And it wastes valuable resources by applying interventions and treatments that we already know are unlikely to be effective. That is why increasing access to accurate diagnosis, coupled with education, is key.

We know the types of interventions that work in FASD. We know that environmental changes and supports, educating staff, support workers and teachers, and comprehensive long-term support plans are what are needed.

Ms. Sheila Burns I wanted to talk a little bit about prevention. Prevention strategies need to resonate with the general population who just need information regarding the impact of alcohol on the developing fetus. Women need to know they should avoid pregnancy if they drink alcohol. Fetal alcohol spectrum disorder can be prevented. But there is a population of women who are alcohol-dependent. These women need specialized supports to cope with the complex issues in their lives. Toronto's Breaking the Cycle program is geared to help these women. A dozen agencies collaborate to bring the supports and services vulnerable women need to enhance their ability to deal with drug and alcohol dependency, to address trauma and abuse, to stabilize their lives and to learn good parenting skills. We know that if we support this group of women, we can reduce the incidence of FASD and provide early intervention programming for their affected children.

Breaking the Cycle also identified a group of women who themselves have FASD, who stumbled through their lives having experienced failure, trauma, abuse and mental illness, and an undiagnosed disability. Those women need the supports offered other adults with developmental disabilities. Both men and women with FASD need access to supportive housing, employment and daily living so they can contribute to their community to their fullest capacity. They need a lifetime of support and a continuum of care.

Bill 77, the act to provide services to persons with developmental disabilities, offers an opportunity to address the needs of these vulnerable adults. It adds executive and adaptive functioning impairments to the criteria for accessing services. A flexible service provision will assist individuals to work, parent and live with respect and dignity.

In a recent study, FASD is estimated to cost Canadians \$5.3 billion annually. In Ontario, we would see huge savings and efficiencies if we ensured that the services these individuals receive were appropriate to their disability and weren't contributing to the problem. With awareness, diagnosis and training, we can begin to align services more appropriately and see better outcomes.

Ontario is the only province that does not have government staff assigned to this issue. The western provinces and territories have worked together for years exploring facets of the disability, providing training opportunities, conducting research and defining and advancing best practices. Ontario is not at that table, which leaves no one to ensure appropriate service provision for the 130,000 individuals in this province with FASD, nor is there a strategy to reduce the incidence rate. We need ministry and government leadership in a collaborative approach, as is demonstrated by this standing committee, to take the lead on this issue. It requires more than the dedication of a few dozen volunteers across the province.

Those with FASD are heavy users of our system's mental health and addiction services. They do not have to be: Appropriate services. Thank you very much.

1710

The Chair (Mr. Kevin Daniel Flynn): Thank you for a very good presentation. Unfortunately, there's no time for questions and answers, but I think you did a very good job.

It's interesting. I just wanted to point out a thing that I think that most of the committee members would have heard: that if you become pregnant, you should avoid alcohol. What you're saying here is that if you drink alcohol, avoid pregnancy, which is turning it around a little bit.

Ms. Sheila Burns: And I think that's a really valid point. I think we do have to look at this differently; that so many women drink and so few—only 50% of women—plan their pregnancies. So the risk of overlap and early complication exists, and that leaves women to worry. I think that if we look at it through a different lens, we can effect change.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today.

CARITAS

The Chair (Mr. Kevin Daniel Flynn): Okay, our next presentation today is from an organization, Caritas. Elio Sergnese?

Mr. Elio Sergnese: Good enough, sure.

The Chair (Mr. Kevin Daniel Flynn): The executive director. You've brought somebody with you today; if you would introduce that person and make yourself comfortable. I believe you've been here since the start of the meeting, so you know what the rules are.

Mr. Elio Sergnese: Actually, I didn't, but I think I have 15 minutes.

The Chair (Mr. Kevin Daniel Flynn): Yes, 15 minutes. Use it any way you see fit. If you can leave some time at the end for questions, that would be great as well.

Mr. Elio Sergnese: Okay. Good afternoon, everyone, and thank you for the opportunity to make this presentation. My name is Elio Sergnese, and I'm the executive director of the Caritas Project, a therapeutic community here in Toronto. This is my colleague Dr. Norma de Castro, and she is our mental health specialist.

I'd like to start by giving a very brief overview of what Caritas does and then move on to more general themes, including what needs exist in the sector, what is working and should be expanded upon, how service providers can be coordinating with other sectors, and the role of the justice system. I'll leave about half my time for questions.

Caritas is a registered charity with over 20 years of experience rehabilitating clients who have the most challenging problems. Our 25-month program is the only one of its kind in Canada, and we have served clients from all over the country. For many of the men we serve,

our care is the last chance they have of leading healthy lives. Residential clients start at our therapeutic community in Toronto and, when they're ready, they move to the next phase of the program at the farm in King City. Unlike typical relocation programs, ours takes a holistic approach, addressing the physical, mental, spiritual, social, emotional and vocational needs of clients in a family-like environment.

Our funding is broken down fairly evenly from three sources: We have client fees, the Ministry of Health and some very successful fundraising programs. Our operating budget is \$1.6 million. We also offer weekly family support groups, and we do prevention in schools. As I'm sure you are all aware, there are many needs in the system, not the least of which is more money, but I'd like to focus on a few specific items we've identified over two decades.

By far the most crucial need is for more semi-independent long-term housing for clients who have completed our program, and what I mean by this is a place where clients can live mostly independently but under the caring supervision of doctors, social workers and, in some cases, parole officers. This is especially important for seniors who are not ready for a retirement home. Oftentimes, clients will graduate from a program and then end up in an environment that is not good for them, where they are not taking their medication or where they have no support system. Often, this includes unhealthy family situations. There is a program in Toronto called Reconnect that does some work like this, but they are overwhelmed, and in at least one case they were forced to place a client in an apartment across town and away from existing support networks. If there is only one suggestion I can make, it is that the government provide more post-program housing.

Another important need is for additional employment and training services in general—and certain clients, especially those with mental health issues, require specialized placements. Naturally, we want clients to reintegrate into society after they defeat their addictions, and this is made much easier if they are able to find work or upgrade their education. We have a teacher come to our site a few times a week, but this is not enough.

There is a service in Toronto called Fresh Start that only hires clients with mental health issues to do cleaning. This is great for the clients, because it takes away the stress of wondering whether they are going to be fired. If they miss a day, for example, they won't be let go. The employer understands and there are special circumstances here.

Youth have special needs in that they require assessment and intervention as early as possible. An untreated mental disorder in a young person can quickly become severe at a young age. Serving ethnic minorities sometimes poses a challenge. Often, family members from outside of Canada do not understand mental health issues or what we are trying to do. In one case I dealt with, the client's mental health issue was seen to be shameful and being in our program was seen as a punishment. Lan-

guage barriers also crop up and can be averted by making translators readily available for use.

Lastly, on the topic of needs, emergency room staff have become more sensitive to the needs of mental health patients, but there is still room for improvement.

What works when it comes to treating mental health and addictions? It's important to avoid the typical institutionalization where everyone is confined to their rooms. Caritas has tried to create a sense of family within the program, which has been highly successful. Giving everyone a role and a purpose helps us do our work, but it also gives clients life skills that they can use after they leave us. However, this kind of a support network should be made available or replicated post-program. For many of our guys, the reason they got into drugs in the first place was because they didn't have somewhere they felt they belonged.

The next thing I want to talk about is how to improve coordination between service providers like Caritas and other sectors or actors. Agencies should develop strong relationships with GPs and psychiatrists. Many clients, when they go to see their doctors, report that everything is fine and that they don't need help—or, more specifically, their medication.

In these cases it would be helpful for the doctors to come to us and say, "Are there any problems you've been noticing?", and so on. Strong communication with service providers can give doctors context and history, ultimately allowing the doctor to better help the patient.

There's also a strong need for building relationships with groups that provide employment, apprenticeship training and education. A volunteer of ours has been in contact with Employment Ontario for several months now seeking support for our clients, but we have had little success.

The last topic I'd like to discuss is the role of the justice system. For the most part, those in the system have accepted that treatment is superior to punishment when it comes to mental health and/or addictions. Probation officers can provide us a lot of support as long as they share this belief. They can reinforce for some of our more troubled clients that if they don't want to be in our program, the only other alternative may be jail. Probation officers, like psychiatrists, need a better understanding of what service providers like Caritas are trying to do. There is a great potential for all parties to work together as long as professional boundaries are accepted and respected.

Thank you for being here today and listening to what health providers have to say. I'll leave you with one thought before I open it up to questions. In Ontario, we attempt to ensure that those in wheelchairs have the same access to things that the rest of society enjoys. Mental health and substance abuse sufferers deserve the same treatment. If we do not give them the skills and support they need to feel part of a community, we are simply fuelling whatever mental health issues exist.

Thank you again, and I look forward to your questions.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Elio, for your presentation.

Christine or Sylvia, we've got about seven minutes, or about three minutes each.

Mrs. Christine Elliott: Thank you very much for your presentation today. I'd like to just ask you some questions regarding the justice system, if I could, because we've certainly heard the frustration of many families, in particular, about accessing assistance for their family member who may have a problem with mental illness but they refuse treatment or they don't have the insight to recognize that there are problems. Do you have any specific recommendations around possible solutions to that dilemma?

Dr. Norma de Castro: Yes, some, because quite a few of our residents come from jail, and they are the most difficult people to deal with in the first five months because of their anger—coming from the jail, and their mentality. They have some kind of jail mentality, so it's very hard for them to even agree and co-operate with our rules and regulations.

1720

So what can I suggest? What I have been doing since being in mental health is, I deal with the residents quite a bit. I have a group with them dealing with their own issues, not so much with the addiction per se, or mental illness, but just adjusting to the environment. That's the first approach before they can become collaborative with it, whatever we do in the program. Is that what you're asking?

Mrs. Christine Elliott: I guess I'm just wondering if there's someone that—often families say, "I can't get my family member into any kind of treatment program because they don't think that there's a problem." There seem to be many impediments to getting assistance for someone. Of course, we're talking about balancing people's civil rights and civil liberties against the clear need for treatment, at least in the eyes of the family. We're really interested in any suggestions you might be able to offer us to how we can deal with that.

Dr. Norma de Castro: What has happened in our situation is that if the family understands the whole condition—we give a lot of support to the family, number one. That's very important. Once the family understands our motive or our philosophy about the program, they become very stern and firm in telling their sons or their daughters, "You need to go into the program or you are on your own." So, there, the family poses a threat to them: "You cannot come home unless you go into the program."

The Chair (Mr. Kevin Daniel Flynn): Thank you, France?

M^{me} France Gélinas: I'm sorry, I missed part of the presentation, but I'm curious to see: How many clients can you accommodate at once?

Mr. Elio Sergnese: We have the capacity to hold 50 people right now.

M^{me} France Gélinas: And this is in your Toronto and your King City—

Mr. Elio Sergnese: A combination of the two; that's correct.

M^{me} France Gélinas: The combination of the two. And do most of your clients stay the full 25 months with you?

Dr. Norma de Castro: Some 95%.

M^{me} France Gélinas: They will stay for over two years with you?

Mr. Elio Sergnese: They don't necessarily agree to doing that in the beginning, but we divide the 25 months up into four phases. We ask that they commit one phase at a time, where the first commitment would be five months. So that gives us five months to explain to them and help them understand why they would need the other 20.

Dr. Norma de Castro: And usually the first five months is adjustment to the whole program, and you have to deal with their anger and frustration and so on.

M^{me} France Gélinas: And is it solely men?

Mr. Elio Sergnese: Yes.

M^{me} France Gélinas: And what are your main areas of referral? How do they get to know you exist?

Mr. Elio Sergnese: In short, I can tell you: from everywhere. We are the last resort. Nobody wants to do a 25-month program. So when you're desperate, we have referrals coming from doctors; we have referrals coming from the justice system—a lot of people will accept conditional sentences, so instead of going to jail, they'll come to our program for, I believe, it's two years minus a day; schools—we've had schools refer their students to us—rather, students who have been suspended, that is. Where else?

Dr. Norma de Castro: We have clients, too, from all over the world. We have one from Russia, from Italy, from France, from Portugal, from the States.

M^{me} France Gélinas: Do they all have a serious mental illness?

Mr. Elio Sergnese: No, not all of them. It's the combination. We have people who have just strictly addiction problems. Right now, 48% of our population has concurrent disorder—mental health and addiction.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Elio. Any questions? Helena?

Ms. Helena Jaczek: Did I hear you right? You have space for 15 or 50?

Dr. Norma de Castro: Fifty.

Ms. Helena Jaczek: Fifty. How many are in Toronto—King City is in my riding, and I feel very awkward because I've never heard of Caritas.

Mr. Elio Sergnese: I hope I didn't cause problems for myself.

Ms. Helena Jaczek: How large is—

Mr. Jeff Leal: She's coming for a tour this week.

Ms. Helena Jaczek: I definitely will be.

How many are in your King township—

Mr. Elio Sergnese: In King City, we have 88 acres of land. Unfortunately, our house can only accommodate 16 people.

Ms. Helena Jaczek: Sixteen?

Mr. Elio Sergnese: Correct.

Ms. Helena Jaczek: Is that, by any chance, on Dufferin Street?

Mr. Elio Sergnese: On Weston Road.

Ms. Helena Jaczek: On Weston Road.

What I actually wanted to ask was: In terms of the ancillary services—Fresh Start and some of the other programs—do you notice a difference between services—accessibility of these services and availability? How does York region compare with Toronto?

Dr. Norma de Castro: How does—I'm sorry?

Ms. Helena Jaczek: How does York region—you must be referring to programs in York region as opposed to in your Toronto facility, you would be referring to Toronto ancillary services, Fresh Start or any other services. Do you notice a difference?

Mr. Elio Sergnese: We've had more success with the Toronto services.

Ms. Helena Jaczek: So you're finding some difficulty accessing services in York region?

Mr. Elio Sergnese: Accessing; identifying, even, whereas it's easier to identify the services that exist in Toronto, perhaps because they're either larger or there are more of them. While it's always difficult to have access to those services, it's easier to get to the services in Toronto. Transportation is always an issue as well for some of those services.

Ms. Helena Jaczek: Could I just follow up? Did your organization purchase the property on Weston Road?

Mr. Elio Sergnese: Yes.

Ms. Helena Jaczek: I see.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today. Great presentation and great questions. It sounds like you've got a wonderful organization.

Dr. Norma de Castro: And we do a lot of school presentations. I believe that this is really the best first step in terms of prevention, as you probably all know. There's a lot of addiction among youth, and we are in great demand to do school presentations in different schools all over.

The Chair (Mr. Kevin Daniel Flynn): Thank you for what you do.

EVA'S INITIATIVES

The Chair (Mr. Kevin Daniel Flynn): Our next presenter today is Eva's Initiatives: Maria Crawford. Maria, if you'd like to come forward.

As you're settling yourself, to the committee, I just wanted to talk to you about a few things. One is that the Ontario College of Family Physicians sent a response to the Ministry of Health and Long-Term Care's discussion paper. It's about this thick. I have a copy and I wondered if other members had a copy.

Ms. Sylvia Jones: I think you should read it—

The Chair (Mr. Kevin Daniel Flynn): I'll read it and tell you what they said?

It literally is about this thick, and everybody else didn't get one so I will give it to the clerk. And there is

an executive summary that's maybe four or five pages. I'll make sure that you each get a copy of that. It looks like it's very well done.

The other thing is, there's a presentation November 3 in Toronto. It's called Making Gains in Mental Health and Addictions, and I'm presenting on behalf of the committee. The staff are going to attend as well, so just so that the other members are aware of that, and if any other member of the committee wants to attend.

M^{me} France Gélinas: At what time?

The Chair (Mr. Kevin Daniel Flynn): I can get you the details. I think it's an all-day conference.

M^{me} France Gélinas: And what time do you present?

The Chair (Mr. Kevin Daniel Flynn): It goes from the 2nd to the 4th, but I'll be presenting on what we've done as a group on November 3.

M^{me} France Gélinas: Okay. Let us know when you present and we'll go cheer you on.

The Chair (Mr. Kevin Daniel Flynn): All right. Apparently I'm on just before Mary Walsh, which is a lot better than following Mary Walsh, I'm sure.

Sorry about that. I just wanted to get some business out of the way while you got settled. Our next presenter, as I said, is Eva's Initiatives. Maria, thank you for coming. If you'd introduce your colleague, you have 15 minutes like everybody else. If you can save a little bit of time at the end for questions, that would be great too.

Ms. Maria Crawford: I'd like to start by thanking the honourable members of the select committee for granting us the opportunity to come and speak to you today on behalf of Eva's Initiatives for homeless youth. I'm Maria Crawford; I'm the executive director of the organization. With me today is Sondra Marcon. Sondra works at Eva's Place, one of our three shelter facilities, and she works directly with the young people that we're here to talk to you about today. Just by way of context, there's certainly a more fulsome summary in the package that we've provided, but Eva's Initiatives is a not-for-profit organization that works with homeless and street-involved youth. We operate three shelter facilities in Toronto as well as a wide range of specialized programs and services to assist homeless youth. We accommodate up to 114 youth every night. I'm going to turn it over to Sondra at this point to speak to you specifically about the young people that we work with.

Ms. Sondra Marcon: We are speaking to you today to stress the dire need for a youth-specific mental health system, and to highlight the fact that there is no such system existing in Ontario. We have a children and youth mental health system that effectively ends at the age of 16, sometimes 18; and we have an adult mental health system. There's no system in Ontario that deals specifically with youth mental health.

Imagine you're a youth service worker at a homeless youth shelter and you're six hours into an eight-hour shift. You think to yourself, "Things are going well," when suddenly a youth comes running into your office yelling for you to come quickly. As you turn a corner, you see blood coming from under a bathroom door and

you hear someone screaming. You reach for your cell phone and dial 911. You try to speak to the youth through the locked door, past his gut-wrenching screams and loud banging on the wall. It seems like forever before the fire department arrives, followed by the police. The police hear the sounds coming from the bathroom and call for backup. Finally, they get the door open and a knife flies out of the hands of an 18-year-old male. A quick-thinking officer kicks it out of the way. The police officers use a taser gun multiple times to subdue the youth. In this situation, the young man I'm telling you about completely severed his penis and one testicle. This is one of many stories we could share with you about youth aged 16 to 24 who reside in our shelters and who are struggling with mental health and/or addiction issues.

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In Toronto alone, it's estimated that 10,000 young people are living on the streets. That is anywhere from 1,500 to 2,000 on any given night. An informal survey by the Youth Shelter Interagency Network in Toronto estimates that 40%, or one in four homeless youth in Toronto, are struggling with mental health issues. This estimate is conservative.

Although the minister's report, *Every Door is the Right Door*, is comprehensive, it's lacking in a key area addressing the issues facing people who are homeless—in particular, homeless youth. As noted in the report, "Ontarians between the ages of 15 and 24 are three times more likely to have a substance use problem than people over age 24." The report also states that youth 15 to 24 are also more likely to experience mood disorders, depression and a first-episode psychosis. These youth are more and more often ending up at emergency shelters with limited supports, unclear diagnoses and exhausted families and caregivers. They are routinely discharged from hospitals to youth shelters with limited discharge planning or support.

Comprehensive mental health services are critical for these 40% of youth involved in Eva's Initiative's programs, and in all shelters across Toronto, who are also suffering from complex mental health issues. These youth experience symptoms and/or diagnoses of depression, bipolar disorder, post-traumatic stress disorder, first-episode psychosis, schizophrenia, attachment and personality disorders, obsessive compulsive disorder, attention deficit disorder, anorexia and bulimia, fetal alcohol syndrome, concurrent disorders, dual diagnosis, body dysmorphic disorder, acquired brain injury, Asperger's, autism and developmental delay, just to name a few.

The shelter system lacks the resources to appropriately respond to these high-risk, high-need youth. With a low number of staff per shift, with limited education and experience, and in addition to working with other shelter youth, these staff must respond to youth with challenging symptom presentations, including high anxiety, withdrawn behaviours, flat affect, inconsistent moods, unprovoked anger outbursts and acts of violence, eating disorders, problematic social skills and boundaries,

paranoia, inappropriate sexual behaviours, self-harm and suicide, and homicidal ideation. The only reliable funding that shelters receive is a per diem rate that, at present, covers only 60% of our operating costs for food and shelter.

Adolescence is the time when most mental health symptoms emerge, and yet the child and youth mental health system will often not intake a youth who is over the age of 16 years. To better serve this population, Ontario needs a youth-specific mental health and addiction system. It is important that this youth-specific system take into account the developmental needs and behaviours of adolescents, as they are key factors in the ability of youth to access and succeed in programs. A youth-specific mental health system must recognize youths' need for autonomy, their risk-taking behaviours and brain development, as well as the unique and unprecedented issues that youth are struggling with today. It is also important to consider the distinct determinants to successfully and productively engage youth in the process.

To better serve these youth, all staff involved in delivering services to this population, including teachers, child and youth workers and hospital staff, should be comprehensively trained and educated on the emergence of mental health in adolescence and the strategies to engage youth in this process.

Homeless youth have more urgent and unique needs, and they come to us because they have nowhere else to go. We were quite taken aback recently when a well-respected psychiatrist commented that youth shelters are fast becoming the new asylums for young people with mental health issues—a shocking statement, but there's a huge degree of truth in that.

Homeless youth access emergency health services more than the general population. The average homeless person has health care costs that are 50% higher than the health care costs of the average Canadian. Increased funding for community-based, youth-focused mental health and addiction programs is necessary to reduce emergency room visits and overuse of hospitals.

These community-based services need to include more youth-specific addiction programs, detox and concurrent disorder programs. Most in-patient addiction facilities have extensive wait-lists and require ongoing contact from the client to ensure interest in participation. This is particularly problematic for homeless youth who are transient. Often youth will relapse and, due to lack of contact as a result of their homelessness, lose their place on the waiting list.

Concurrent disorders are on the rise. A recent study from the Centre for Addiction and Mental Health found that one in five people treated for mental health disorders in Ontario's hospitals and mental health clinics have co-occurring substance use issues. The majority of mental health services that service youth aged 16 to 24 who are also struggling with substance use issues will not provide services until the substance use issue is addressed. This is not realistic or appropriate for most youth.

The image we leave you with of homeless youth with mental health and/or addiction struggles should not be

one of self-mutilation. We should not have to share with you that this young man's story ends with his body being found in Lake Ontario two weeks ago—he committed suicide—that the lack of support and housing had contributed to his death. Unfortunately, this young man's experience is not unique. We have had a number of young people take their lives as a result of not being able to access the services and supports they require. In a province like Ontario, this is a tragic disgrace.

The image should be one in which youth are given the right opportunities and supports: help and guidance in transitioning from the shelter system; assistance in reconnecting with families and developing systems of support; job training and employment opportunities; and most of all, are healthy and actively engaged in their own recovery. All of this can be achieved with a youth-focused mental health and addiction system.

Until such a system is in place, we believe it's imperative that shelters for homeless youth receive funding for vital services they provide in attempting to address the increasing number of youth with mental health issues who end up in the shelter system. These services can be provided via the shelter system in a much more cost-effective manner than if attached to larger public institutions and can provide more appropriate and accessible services to these vulnerable citizens. We have developed a model and a specific funding proposal which is currently resting with the Minister of Health, but have had no response to date.

We thank you for your time, for hearing us today and for your thoughtful deliberations on this pressing issue.

The Chair (Mr. Kevin Daniel Flynn): Thank you for your presentation. We've got time for probably one quick question and answer, starting with France.

M^{me} France Gélinas: So would you see mental health, addiction, all of the services like employment services, support services and transitional housing being for this age category?

Ms. Sonda Marcon: Yes—I mean, ideally. The age category has such a unique set of needs that aren't being met in either the adult or the child system, so it would be about creating a specific system that meets the needs of these youth. A 21-year old going into the adult system doesn't necessarily have the same needs as a 60-year old in the adult system, and often they're sitting in a room with a bunch of 40-, 50- and 60-year-olds, at 21, being expected to access services in transitional housing, in group facilities, in all of those places. It just doesn't fit who they are or what they're about.

M^{me} France Gélinas: Very good. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Any questions from this side? Liz.

Mrs. Liz Sandals: We've heard in lots of places about the gaps, particularly at this transitional age, but not so much, perhaps, from the point of view that you're bringing to us, which is the homeless youth—the kids who just haven't accessed services anywhere. Are the kids you're seeing in Toronto shelters Toronto kids, or are you seeing them from all over the province? I'm just wondering, are you the collection point for the province?

Ms. Sondra Marcon: Yes. I would say we see youth from all over. And some of the youth in our shelters do access services; they just haven't been effective for them.

Mrs. Liz Sandals: And that was actually my next question: Is the problem sometimes that the young person has chosen not to access services—because that's often what you get with mental health or addiction—or is it that there were no services to access?

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Ms. Sondra Marcon: I think it's a little of both. It's challenging for youth to access services, and walking into a big institution is challenging for any youth to do without support. But it's also the fact that wait-lists are eight, nine, 10 months long, and when you're dealing with homeless youth who access the homeless shelter—and they're bouncing from shelter to shelter because they can't be maintained or they're uncomfortable or their paranoia leads them to not feel safe. By the time the eight months comes up, you often don't know where they are. I had a phone call from a provider and I couldn't tell her where a youth was, so—

The Chair (Mr. Kevin Daniel Flynn): Thank you for that answer. Christine or Sylvia?

Mrs. Christine Elliott: Sure, just a quick question. Your reference to the Every Door is the Right Door strategy—I gather what you're saying is that your particular door hasn't been recognized as being as important as it is, that you're seeing youth and you're the ones who have access to them on the spot.

I really applaud you for coming to speak to us about it and I'd really be interested in more about your proposal that you have submitted to the Ministry of Health. Is there any way that we could get a copy of that?

Ms. Maria Crawford: I'd be happy to. If you'd just direct me if I do that through the clerk or—

Mrs. Christine Elliott: Thank you. That would be wonderful to have that.

The Chair (Mr. Kevin Daniel Flynn): Wonderful. Thank you very much for coming today. Thank you for your presentation.

CITY OF TORONTO, SHELTER, SUPPORT AND HOUSING ADMINISTRATION

The Chair (Mr. Kevin Daniel Flynn): Our final presentation of the day comes from the city of Toronto Shelter, Support and Housing Administration—Phil Brown. Make yourself comfortable. Like everybody else, you get 15 minutes. You can use that any way you see fit. If there's any time at the end, we'll try and share it out as much as we can. Thanks for coming.

Mr. Phil Brown: Thank you very much, Mr. Chair. Good evening, and thank you for this opportunity to speak to you. I'm here to represent the interests of the most vulnerable in our province who are mentally ill and have addictions. These are people who are homeless and those who are precariously housed.

I think you've just had a reality check from one of our valued partners, Eva's Initiatives for homeless youth.

I thank the Ontario government for working to create a long-term strategy for mental health and addiction services and for establishing this committee. I want to respectfully suggest that, in doing this work, you think beyond the matters of conventional health care delivery alone.

My name is Phil Brown, and I'm the general manager of Shelter, Support and Housing Administration at the city of Toronto. This is the division of the city that is responsible for funding and administering more than 90,000 units of social housing. We manage the emergency shelter system, and we coordinate services for homeless people delivered by local community agencies and funded by the city, provincial and federal governments.

Along with the Ministry of Health and Long-Term Care, we also fund Habitat Services, a program that provides housing support and subsidy in boarding homes and rooming houses for more than 900 people with psychiatric illnesses. We also operate a street outreach and housing program called Streets to Homes. This provides housing assistance and intensive case management supports to people who live outside or who spend their days on the streets, to help them find and keep housing.

My main message to you this evening is this: For the most vulnerable, mentally ill people in our province, housing is the first medicine to consider.

Many of the people who use the shelter system in Toronto do so for economic reasons. Most use the system for a short time. There is a core group who stay in emergency shelters for long periods of time, sometimes years, because their ability to earn a living or to live on their own is compromised by mental illness and/or addictions. For them, the shelter system, which was originally intended to provide only temporary emergency shelter, has become their de facto home.

Let me tell you about just one of our shelters. Seaton House is Ontario's largest men's shelter. It has 580 beds, but at least 280 of these provide long-term care for men with physical, mental and addiction issues. A recent survey of long-term residents by researchers from our partners at St. Mike's and CAMH documented the high-needs profile of this population. Forgive the statistics, but they outline a powerful story of how service systems funded by other orders of government are failing a group of people profoundly affected by mental illness and addictions.

The survey revealed this: 33% of long-term shelter users have a diagnosed mental illness; 35% have an alcohol addiction, and 50% have an addiction to other drugs; 18% have a diagnosed concurrent disorder; and a mere 17% were identified as able to maintain a home of their own without some level of support.

Seaton House is just a five-minute drive from the Legislature, and I would be more than happy to take you on a tour of this or other shelters.

While Seaton House, like other shelters in Toronto's system, provides a variety of health care supports to clients who should be served by the health care system, it

is funded as an emergency shelter facility rather than a health care facility. For each occupied bed, the province pays the city \$33.25 per day. The actual daily cost of operating one occupied bed at Seaton House is \$104. The city picks up the difference of \$70. As Eva's just mentioned, the shelter system lacks resources.

Many of the men at Seaton House, as well as many of the women and families in our other shelters, are in homeless shelters because they have been referred from prisons, emergency rooms, psychiatric hospitals and long-term care facilities—publicly funded institutions that have been unable to meet their complex needs. So they are referred to an emergency shelter.

We do our very best to help our shelter clients find appropriate housing because we want to end their homelessness, not manage it. Why do we emphasize housing? Because we believe that whether you live in Scarborough, Guelph, Peterborough, Thunder Bay or anywhere else in this province, your first need is for a permanent home, not a bed in an emergency shelter. Only with the dignity, safety and security of a place to call home can you begin to deal effectively with the other issues, mental illness and addictions being among the most common. We believe home is where it starts. We use the housing-first approach throughout all our services. We see housing as a right.

In Streets to Homes, and elsewhere in the work we do, we have seen empirical evidence that housing with appropriate supports is good medicine. We are seeing improved mental health and fewer addictions among clients who we have housed.

Since we started Streets to Homes in 2005, we have helped more than 2,600 people move into permanent housing directly from the street. A critical part of the program is to provide people with follow-up supports for up to a year. These come in the form of a support worker who assists his or her newly housed client to get settled into their new home, connecting them to resources in the community, most often health care, employment training and resources. More than 90% of the people we help to find homes remain in their housing. Most live in private-sector apartments, not social housing or supportive housing.

A post-occupancy survey we did in 2006 shows that having housing also results in improved mental health and reduced alcohol and other drug use. Again, it cannot be housing on its own. There need to be supports in place that provide consistent and coordinated follow-up.

We've also seen the importance of post-occupancy support in the Hostels to Homes initiative. This is the Ontario government's pilot project that essentially uses shelter per diem funding to provide supports to newly housed people who were previously users of the shelter system. We are finding that with the assistance of their follow-up worker, long-time shelter users are able to remain in their new homes, deal with their illnesses and settle into the community. We thank the provincial government for this important pilot project.

Housing is not only good medicine, it's also good economics. We can demonstrate that having housing with

appropriate supports not only improves the health and quality of life but also results in a clear reduction in use of costly emergency health and justice services. In our survey, a group of six high-needs clients on the street used an average of at least \$36,000 each in emergency and health services in the last year they were homeless before they were housed. Had we not been able to help the six people in this group, we estimate that they would have cost the system more than \$2 million in health and emergency services over the next 10 years. In comparison, it costs less than \$15,000 dollars a year—\$41 dollars a day—to house these individuals with supports. The bottom line is, do nothing and it costs you \$2 million over 10 years; house them and it costs you \$1 million over 10 years.

As I've described, at the city of Toronto we've already made many successes in developing innovative programs to help homeless and vulnerably housed people with mental health issues. But there's clearly more work to be done, and we're pleased that this committee will be advancing support for these types of innovative approaches and looking for ways to break down silos and integrate services across different jurisdictions and sectors.

In particular, and in closing, I would ask for your help in the following areas:

- (1) Provide sustainable, ongoing funding for shelters which covers the true costs of providing services to homeless people with complex mental health and addiction issues. All shelters, including Eva's, across Ontario need more than \$33 a day.

- (2) Implement a new funding model for shelters which supports a housing-first approach and enables people to move more quickly from shelters back into housing.

- (3) Invest funding in programs that provide intensive case management to help vulnerable people remain in their homes.

- (4) Provide ongoing sustainable funding for the Hostels to Homes program and make it permanent.

- (5) And finally, we need your help to make sure that there are affordable places to live for all people who are mentally ill and have addictions.

The Ministry of Municipal Affairs and Housing is currently holding consultations to develop a 10-year affordable housing strategy. This committee has a unique opportunity to ensure that your mental health and addictions strategy merges seamlessly with the Ministry of Municipal Affairs and Housing's 10-year affordable housing strategy so that there is a coordinated, collaborative approach to providing housing with supports to meet the needs of all Ontarians.

Recently, Toronto city council overwhelmingly voted to approve Housing Opportunities Toronto, and we've left a copy for you—an affordable housing action plan. Helping homeless and vulnerable people find and keep homes is a key strategic theme of the city's plan. However, unless we think outside the traditional lines of responsibility, we will not be improving access to services for homeless and vulnerably housed Ontarians with mental illness and addictions.

Investing in housing solutions is cheaper and more effective than having people end up in the emergency room at \$212 a visit, a psychiatric hospital at \$665 a day or in jail at \$143 a day. Again, we can house clients for \$41 a day and keep them housed, and happily so. If you're mentally ill or have addictions, having a home is the beginning of addressing these issues. Housing First is great for clients and great for taxpayers, a true win-win.

Thank you, Mr. Chair.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Phil. You've left about a minute for each side here. Any questions from the government side? Christine? Sylvia?

Mrs. Christine Elliott: I'd just like to thank you very much for coming and speaking to us today because I think you have just clarified for us what we've been hearing, sort of, from different groups, but it hasn't been really clearly stated—the high proportion of people who are homeless that do have mental health and/or addiction problems and the need that you have to have housing coupled with support, and that's key to success. Thank you very much for stating it in such clear and simple terms for us.

Mr. Phil Brown: Thank you very much.

The Chair (Mr. Kevin Daniel Flynn): France?

M^{me} France Gélinas: I don't know if you'll be able to answer this: I certainly support the Housing First strategy. I think it is the way to go. Were you able to quantify this? You mentioned that you need \$31.3 million in the shelter system in Toronto. But if you were to implement Housing First for everybody who needs it—any idea of a number?

Mr. Phil Brown: Thank you for the question. We don't have one number for that. But in the package that we left with you, we do show our cost-benefit analysis of housing somebody as opposed to putting them in jail or leaving them in an emergency room. So we do have that cost-benefit analysis. I'm happy to chat further if that's possible.

The Chair (Mr. Kevin Daniel Flynn): Final question from Liz.

Mrs. Liz Sandals: Yes, I was sitting here when you went by before, trying to reconcile this in my mind.

Thank you for your presentation. On page 3, you say the actual cost of operating one occupied bed at Seaton House is \$104 a day, and then over in your final conclusion, toward the end, you talk about housing clients with supports for \$41 a day. Is that the difference between shelter housing and permanent housing? Can you explain that discrepancy?

Mr. Phil Brown: Yes, indeed. Those are the figures for Seaton House; the \$100 is for Seaton House. On average, across our shelter system, it costs about \$69 a day for an occupied bed for a shelter client. We also say that it is cheaper to keep people in housing. Emergency shelter in and of itself is an expensive form of accommodating people. That's why we're saying housing first. Housing is the best solution for clients and it's also one of the cheaper ways of doing it.

Mrs. Liz Sandals: So the \$41 a day, can you tell us what model that is, just so that we're clear?

Mr. Phil Brown: Yes. Again, there's a more detailed package in the cost-benefit analysis that we left with you, but that is the cost of an average rent, plus ongoing supports to help keep that person housed.

Mrs. Liz Sandals: So that's monthly rent plus some salaries for support?

Mr. Phil Brown: Correct.

Mrs. Liz Sandals: Okay.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Phil, thank you, Liz, and thank you, committee.

Mr. Phil Brown: Thank you very much.

The Chair (Mr. Kevin Daniel Flynn): Thanks for coming today.

We're adjourned.

The committee adjourned at 1753.

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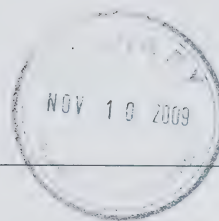
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Select Committee on Mental Health and Addictions

**Mental Health
and Addictions Strategy**

Comité spécial de la santé mentale et des dépendances

**Stratégie sur la santé mentale et
les dépendances**

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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

SELECT COMMITTEE ON
MENTAL HEALTH AND ADDICTIONSCOMITÉ SPÉCIAL DE LA SANTÉ
MENTALE ET DES DÉPENDANCES

Wednesday 28 October 2009

Mercredi 28 octobre 2009

*The committee met at 1604 in committee room 1.*MENTAL HEALTH
AND ADDICTIONS STRATEGY
HALTON REGION OUR KIDS NETWORK

The Chair (Mr. Kevin Daniel Flynn): Our first presenters today, if we can call to order, are from an area I'm really familiar with, Halton Region Our Kids Network. We've got Mary Beth Jonz and Joyce See with us today. If you'd like to come forward, make yourselves comfortable. There's some fresh water there and some clean glasses, I hope. Mary Beth and Joyce, you've got 15 minutes, you can use that any way you see fit. If you would like to leave some time at the end for any questions or discussion, that would be good, but it's entirely up to you. It's all yours.

Ms. Mary Beth Jonz: Joyce is going to begin.

Ms. Joyce See: I'm going to start. You have a package of information in front of you that we'll refer to as we go through. We're going to talk about some issues about mental health that you will know something about. We're going to talk about some local successes and then, at the end, make some suggestions for things that might change.

The issue of children's mental health obviously—you're delving into this issue you know of. One of the issues we wanted to talk about was the issue of parental mental health and its impact on the ability of service providers to deal with child's mental health. You can't engage the child without engaging the parents, and closer links are required with the adult mental health sector; it's needed to be acknowledged in some ways.

Just to give you some examples, with our HBHC, our Healthy Babies, Healthy Children program in Halton, our high-risk families, of those high-risk families, about 40% of them had one parent who had an undiagnosed mental health problem or that the service provider would have seen, that there were mental health issues that hadn't been addressed and it was impacting on the family's achieving its objectives.

Our mental health provider in Halton, which is called ROCK, Reach Out Centre for Kids, talks about 47% to 50% of the children they treat having a parent with a mental health problem. Before they can get to treating the child's mental health, they have to work with the parent. The psychiatrist at ROCK also talks about 100% of the

families who are in the compass program, and our compass program is for the very highest-risk families, in 100% of those families, one of the parents would have a mental health problem.

Continuing with some of the issues, we have siloed services, which you'll know about, which I think is one of the purposes of this committee. There are a number of ministries who mandate mental health services but there are few bridges between those systems, and the lack of those bridges makes it difficult for families to receive service.

The other piece for Halton which is a huge issue is our population growth. To give you a bit of a sense of that, we have had a 25% increase in children zero to 18 between 1996 and 2006. In our Healthy Babies, Healthy Children program, we've gone from 3,900 births in 2000, and we're anticipating 5,300 births this year. For Healthy Babies, Healthy Children, without any increase in the funding of that program, the early intervention, which is the purpose of those programs, becomes more difficult to deal with.

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The next slide just talks about the four areas that we want to talk about. I know you don't want to just hear about the issues. You've gone across the province and the world. We also want to talk to you about some of the solutions and some of the things we're doing locally that we think could have an impact across the province.

I'd like to talk about the Our Kids Network. In the package that we've provided you with today, there is a structure which I'd like to look at a little bit with you. I think the two areas that I'd like to focus on in this structure are the children's mental health and developmental services, and the research and evaluation.

But before I get to that, the Our Kids Network actually started 12 years ago, and the key was the Early Years at that point. We've grown and evolved since then, and in the last five years, we actually have signed protocol and financial partners to support this, but our main function is to look at service integration for those children, youth and families who are most at risk but provide it for whole communities. So Halton region health and social services, our police services, all our school boards, our children's aid society and our children's mental health are our key financial protocol partners for this model.

As I said before on the structure, one of the things we feel we can make a difference in, and see what difference

we've made, is with our report card, so we've provided you with a report card. It's a large document. We've also given you the executive summary that's attached to that, which breaks it down. But when we move forward, what we looked at in integration, and when we talk about silos and some of the issues, is an ecological model, which is also in your package, that looks at the ministries that you're most familiar with as well as all the local pieces. But the core is the child and the youth and how we all have to integrate together and focus on what the core is, which is the child and youth, and mental health is one of those key areas.

With our report card this year, we've identified seven population results and indicators, which we will be evaluating through results-based accountability. If you go to pages 58 to 60 in the report card, it really talks about the results-based accountability and how we want to turn the curve.

Kevin was able to come to one of the local community forums, which was great. We held five of those to introduce the report card to the community and to help communities identify their key issues. In all five of our communities, they identified children's mental health as their prime key issue. So we know with the report card, and what we have to do locally is to turn the curve on how we're working with children and youth with children's mental health.

We feel this is one of our key models of early intervention and prevention—to work with families at risk, to look at health issues, mental health issues, poverty and the determinants of health. So this is a key driver for us in our local community.

The next integration example we wanted to talk to you about is the North Halton Child and Youth Psychiatry program. It's a collaboration between public health; the North Halton Mental Health Clinic, which is administered by the region of Halton but is a psychiatric outpatients for adult programming; and Reach Out Centre for Kids. On our advisory committee, we also have the addictions programs within Halton as well as our educational partners. The North Halton Child and Youth Psychiatry program is 100% funded through the region of Halton. We receive referrals through family physicians and other professionals, and it provides services to children from four to 18 years of age.

We started the program on November 1, 2008, and we're just at the end of our first year. We will have had about 210 families referred through the program. It's a psychiatrist, a social worker, a nurse and then two family therapists that are provided through the Reach Out Centre for Kids.

An example of a young woman who was a client of the clinic: a 15-year-old who was becoming increasingly aggressive at school, and it had come to the point where the school had determined that she was not safe to be allowed back in school. Through some outreach, she was connected with the clinic, and the social worker working with her mom, and the nurse working with the young woman convinced her to talk to the psychiatrist who

diagnosed her with ADHD and some beginning conduct disorder signs. Through some therapy, medication etc. she's now back in school and she's better-connected with her mum and her mum feels that she's got her daughter back. That's an example of one of the children.

In your package you will see—I'm afraid it's a little dry—a logic model that tells you the different components of the program. It's an example of that bridge that we talked about in the first slide. It's bridging the children's mental health sector, the Ministry of Health and Long-Term Care-funded North Halton Mental Health Clinic and then the public health programs, as well as education.

Ms. Mary Beth Jonz: Due to the essence of time, service coordination is the next one, and it's one that we believe in as a key component for any family that has multiple service providers, and most of our children and adults who have mental health problems have multiple service providers or they have no one. That seems to be the distinction. Service coordination is something that we developed 13 years ago now, I believe. Healthy Babies, Healthy Children was the first to move this forward, but the key component of this was to ensure that families had the opportunity to work with all their service providers for one plan. What we hear repeatedly from our families with mental health issues is that they tell their story over and over again. I have provided an example; I could provide you probably about 400 examples of how this is working in our community because as you can see we've trained over 200 service providers in this model of service. This is something that we require to be offered to all families who need that extra support and who have more than one service provider that they're working with. In the essence of time, I'm not going to give you the actual example I was going to use, but it's here and we will take questions at the end.

The other piece is the infant/child mental health program that we're offering, and it's really an integration of services and collaboration. What I want to reiterate is that the early years represent the first and the most critical stage of the entire life course. The things that happen to us early on, the environments and events to which we are exposed can have immediate, delayed and long-term impacts on our overall health, particularly our mental health.

With the Our Kids Network in the Halton region, we have put a lot of resources and collaboration in those early years. But in saying that, I do want to reiterate that our children's mental health facility, ROCK, has a 380 working days'—almost two years—wait list for psychological assessment for the earliest child around attachment. We know there can be no treatment plan if there hasn't been any assessment. So with our demographics, which we reinforced in the beginning, we still struggle, even with integration, to meet the needs of these children. There is a handout as well that details the levels of intervention for infant and child mental health.

Ms. Joyce See: The last example that we're going to talk about is our Youth Net program. Youth Net is a

mental health promotion program that we provide to young people in high school. It's a mechanism for identifying young people early who have a mental health problem. It's provided through a classroom setting. There is a survey that's done, and about 5% of the young people who participate in the Youth Net program are identified as needing clinical support. So those are just kids—you have 30 children in a classroom and you divide them in half and in 5% of those 30 children, one of them will need a mental health clinical follow-up because of suicidal ideation etc. Those are the unfound ones. It's a partnership between the Canadian Mental Health Association, CAMH, the Centre for Addiction and Mental Health, the local YMCAs and our school boards. It incorporates a program called TAMI, Talking About Mental Illness, that CMHA provides.

Then our last slide, really, is looking at some of what we think might be solutions. You can read some of those details. The one we wanted to highlight, again in the interest of time, is one that we think is an easy one, and we've had lots of discussion about this: the use of health care resources differently. We know that we have six child and adolescent psychiatrists in Halton, some who work only a day a week, some maybe two days a week. So there are six physicians, but they don't work very much.

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One of the issues that happens a lot is that the children are medicated, prescribed medication, and then the psychiatrist is the only one who can monitor that medication. Family physicians are very leery of psychiatric drugs in children, and so they aren't happy taking the children back. By creating some kind of role for the nurse practitioner, public health nurses or other nurses and the creation of medical directives under the jurisdiction of the psychiatrist, there are ways, I think, of taking that psychiatric time and using it in a much more efficient way, so that you can spread it more.

Some of the other things we've talked about are the funding issues, which you've talked about, and looking at one-stop shopping for families so that they don't have to keep being assessed over and over again, which is, I think, what happens with a lot of services. Making Services Work for People started along this path but never required service providers to integrate and have a common definition for integration. It allowed people to do what they want with only minor changes and tweaking to their existing systems, and that continues today.

Ms. Mary Beth Jonz: So our last word is that we want you to do what works best for children, youth and families and not for systems, governments and organizations. We're a part of that—we both work for a regional government—but I think one of our mantras with our kids has been, "The child is first." We need to make our systems work for the child instead of working for us.

So that's our message to you that we want to reiterate. We're passionate about our kids and service integration locally, and on a daily basis try to drive this message

home in the work that we're doing with our own staff and the community.

So, any questions?

The Chair (Mr. Kevin Daniel Flynn): Well, unfortunately, you didn't leave any time for questions.

Ms. Mary Beth Jonz: Oh, I'm sorry.

The Chair (Mr. Kevin Daniel Flynn): But you made an excellent presentation, and thank you for that presentation. I know what wonderful work you do, and now everybody at the table knows what wonderful work you do. I think there's something to be learned from what you do in Halton on a daily basis. So I really do want to thank you for coming today and making your presentation.

Ms. Mary Beth Jonz: Thank you for providing this time for us.

NATIONAL ASSOCIATION FOR THE DUALLY DIAGNOSED

The Chair (Mr. Kevin Daniel Flynn): Our next presenter this afternoon is from the National Association for the Dually Diagnosed: Susan Morris, the clinical director. You must be Susan.

Ms. Susan Morris: Yes. I was going to introduce—

The Chair (Mr. Kevin Daniel Flynn): Good guess?

Ms. Susan Morris: I'll clarify.

The Chair (Mr. Kevin Daniel Flynn): If you'd introduce your colleague.

Ms. Susan Morris: Yes, I will.

The Chair (Mr. Kevin Daniel Flynn): You were probably here at the start. Everybody gets 15 minutes; you use that any way you see fit. If there's any time at the end, we'll just share that amongst the parties.

Ms. Susan Morris: Okay. So I am Susan Morris, but I'm actually the president of the national association of dual diagnosis in Ontario. My colleague is Mr. Jim Johnston, who sits on the board of NADD Ontario and will also be speaking.

I believe you have a package with some slides. We're talking about children, youth and adults with developmental disabilities and mental health needs, and in that regard I'm talking about mild, moderate and severe disorders of intellectual disability, including fetal alcohol spectrum disorders and autism. We're not going to go through each slide. I'm going to highlight some things and point to the slide, and then I'll turn it over to Jim, who has a much more compelling story to tell than I do.

NADD Ontario is a chapter of an international association, and we provide information resources on practice, services and supports. We also advocate for excellence in education and training.

Turning to slide 5 to give you a sense about who we're talking about, I want to point to the first bullet, which says that 38% have mental health difficulties. Overall, first of all, this slide really gives you a sense of both the health and mental health issues that are experienced by individuals with developmental disabilities. If you turn that 38% into numbers, we're talking, at a conservative rate, 100,000 Ontarians, which in fact is quite similar to

the prevalence of individuals with schizophrenia and also is two to four times more frequent than for the general population.

In thinking about our presentation today, on slide 6 we organized our thinking conceptually based on service and system-level integration, with "integration" obviously being the key word.

Slides 7 to 9 provide you existing examples of integration in those two categories and also provide some references for you.

Turning to slide 10, this is where we get to our recommendations for today. Really, the point here is that individuals with a dual diagnosis must be incorporated into any reformed mental health and addictions system. But unfortunately, they also provide the best example of the worst that can happen when you have complex, more than one need.

With that in mind, we have some recommendations, the first being a flexible system structure, starting not just at a service level but at an interministerial level, so that there is a culture of integration and working together across the various ministries.

Secondly, of course, it requires the ability to move flexibly between systems, like moving from children to adults and so on. I think it's notable that although this is being sponsored by the Ministry of Health and Long-Term Care, the trajectory of an individual's illness and recovery means that their involvement with the Ministry of Health is rather limited and in fact periodic, as opposed to housing, ODSP and primary care services. We have to really think about the structure of the system in that regard.

Then, of course, resources for service and system-level integration: There's a history, particularly within health but within other ministries, that system navigators and case management is not funded or supported.

Turning to page 11, I talk a bit here about the funding formula, particularly with regard to treatment—the focus on funding is more around hospital beds than it is around community support—and of course the need for a competent workforce and career paths.

Training in mental health is not a priority for nurses. Training in developmental disabilities and dual diagnosis only recently became an elective, but not a requirement, for psychiatry residents.

And then, finally, the notion of a continuum of services: Just like for health care and diabetes, individuals with developmental disabilities should have access to specialized and knowledgeable services so that the system is tiered and people move through as necessary.

I'm going to turn it over to the last slide and to my colleague, Jim.

Mr. Jim Johnston: Thank you for the opportunity to talk about what the challenges are for families who have a family member with dual diagnosis, which includes myself.

As our children with intellectual disabilities age, mental health issues become more apparent. Our family's

issues really started in the teen years and became worse as appropriate services were difficult to find.

I'm sure you'll understand how rejection, teasing, loneliness and isolation for someone with an intellectual disability can lead to depression and anxiety, emotional outbursts, anger and aggression.

Having a child with a dual diagnosis creates great pressures in the family. As the mental health issues manifest themselves, the family is unsure of how to help the individual. Are the behaviours the result of the intellectual disability or are there other factors involved? Stress and frustration affect all members, often leading to physical or psychological symptoms in family members. Help seems fragmented and remote. When a professional or team has the knowledge and training to really help the family as a whole, the difference can really be profound.

Abuse, and particularly sexual abuse, has a significant impact on those with an intellectual disability; it's four to five times more likely in this population. Many can't communicate. They make poor witnesses in court and they become easy targets. If you can imagine the impact on a normal person's life when they are sexually abused, you can barely imagine what a person goes through who can't talk about it and can't express their anguish. If there are mental health problems, they are worsened; if there are not, they may be triggered. Many families, including ours, have gone through this trauma.

A friend's son, who was sexually assaulted by a priest, is now labelled a difficult case, with severe behavioural problems. Medication has meant a weight gain of 125 pounds, with accompanying health problems. The family can find no agency which will support him, so he lives at home with his family, who are also in crisis. How can our system fail these individuals so badly?

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Many consumers are undiagnosed or diagnosed in one aspect only. Some are identified with intellectual disabilities as children but may never have had their mental health needs identified or been reassessed as they aged and experienced stress at various stages in their lives. These mental health issues often show up as behavioural problems, and social workers, the police and others treat the behavioural problem without identifying or treating the mental health need, which can be very unproductive. If there is an undiagnosed mental health issue, a crisis will almost invariably result.

I wonder why we don't have a system where health and developmental sectors co-operate to determine the best for each consumer, which would then drive required changes to the system. I know there's a joint policy guideline between health and MCSS for the provision of community mental health and developmental services for adults with a dual diagnosis, but from my perspective, I've seen little implementation of that policy.

It can be complex to understand how intellectual disabilities and mental health problems interact. Mental health problems can be mistakenly seen as part of the intellectual disability. If a person is impulsive, withdrawn or irritable, this may be attributed to the intellectual

disability, and many are improperly diagnosed and overly medicated.

Parents need flexibility. Some parents with children with a dual diagnosis are willing to design a program themselves to fit their children's needs. Individualized funding is a way of providing this flexibility, but funding is scarce and most parents are unable to access adequate funding of this type.

But each individual is unique. Each case needs an effective assessment so proper supports can be developed. Unfortunately, there are few professionals in the field knowledgeable in assessing and treating those with a dual diagnosis. Training of medical professionals and workers is key.

Developmental agencies often do not have the capability of dealing with someone with a dual diagnosis since there is little training on mental health matters, yet the staff are expected to deal with some of the most difficult issues and behaviours.

Some agencies are unwilling to accept those who have mental health needs with the accompanying behavioural issues. They are disruptive to the day program or group home and take more staffing. Government funding must be flexible enough to recognize this and step up to those issues quickly.

Families that we deal with continue to ask for:

- co-ordinated assessments, where developmental, mental health and physical health factors are all assessed and integrated so that an effective plan can be created;

- accreditation or some other measure of quality that allows families to assess which agencies meet or exceed standards of excellence in their programs;

- recognition by government that workers in this field must be highly skilled and paid. Current salaries are not enough to attract and keep good staff;

- access to case management support that can help the family navigate both sectors and receive general support to keep the family unit strong;

- assurances that services will be there when families can no longer support their children;

- better education for medical and support staff in the field of dual diagnosis;

- flexibility, including individualized funding; and finally and perhaps most importantly,

- respect for our children, seeing them as valued members of society.

To conclude, I believe we have a moral obligation to work together to change the system so that our children can live a life that has meaning and gives them a feeling of worth and acceptance in the community.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Jim. Thank you, Susan. You did leave some time for questions; that's great. We've got about a minute each. Christine, if you want to—

Mrs. Christine Elliott: Thank you very much for coming to present today. You've highlighted really effectively some of the challenges that are faced by people who have a dual diagnosis. Some of the housing issues, I think, are particularly relevant. I come from

Durham region. I've met with many families where they're trying to find a place for their family member to live safely and comfortably, and there are just very few facilities available. That's certainly on our radar as we consider this. I thank you.

I also appreciate the inclusion aspect of it. I think we still have a lot to learn about how we can be truly socially inclusive. Thank you very much for bringing that forward.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Christine. Any comments, Howard, or questions?

Mr. Howard Hampton: I have several questions, but the housing issue is one that constantly jumps out at me. I wonder if you have any suggestions. It doesn't matter if you come from large communities in Ontario or small communities in Ontario; the need for supportive housing, housing that has services attached to it, is huge. Do you have any ideas?

Mr. Jim Johnston: Well, I think that if there's an integrated assessment in the first place, you realize how much support the person needs. The tendency now is to say, "Well, an adult can move into semi-independent living," and with people with a mental health need and an intellectual disability that just doesn't work. So you have to assess the person.

When you realize the need after that assessment, you realize that you have to have a supported group home, and then it's—you pass the ball over. You need money. You need to buy the home and you need to staff it, and that becomes the issue.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Jim. Anything from this side? Maria?

Ms. Susan Morris: Can I make a comment?

The Chair (Mr. Kevin Daniel Flynn): If it's really brief.

Ms. Susan Morris: Really brief. If we had 2,000 people on a waiting list for some kind of heart care, we wouldn't stand it. We have 2,000 people or more in Toronto waiting for housing. We withstand that.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Maria?

Mrs. Maria Van Bommel: I just wanted to ask Jim: You talked about the point where you realized your child has more than just developmental challenges. What age was your child when you realized that this was beyond just developmental?

Mr. Jim Johnston: I think when we really began to realize it was when they were in their early teens. I have two children who have intellectual disabilities, and when they were children we just thought it must be part of this intellectual disability. It was confusing and difficult and hard to find services, so the outbursts and everything, it was just, that's the way they were. It was only a little later that we began to get some advice about, "This may go beyond this."

Mrs. Maria Van Bommel: So do you think that it actually started well before their teen years, then? When they were still really small children?

Mr. Jim Johnston: I don't know. I wish I knew. I wish I could give you an answer to that. It may well have. I mean, my daughter went into a severe depression and we realized that was a mental health problem, and we began to deal with depression now as opposed to an issue of an intellectual disability.

In their early years, you know, it was hard to say. If we had had a good assessment it might have been better.

The Chair (Mr. Kevin Daniel Flynn): Thank you for a wonderful presentation. You did a wonderful job of getting your point across, and thank you very much for joining us here today.

CHRISTINA JABALEE

JENNIFER TAKACS

CAROL FARKAS

The Chair (Mr. Kevin Daniel Flynn): Okay, if you look to your agenda for the day, two of our delegations, the one at 4:30 and the one at 4:45, are not coming today. However, Christina Jabalee is going to move up on the list, so if you'd like to come forward, Christina, and whoever you've brought with you. Make yourselves comfortable. There are probably some clean glasses there and some fresh water. There's even a microphone for the baby, if—

Ms. Christina Jabalee: He has a lot to say.

The Chair (Mr. Kevin Daniel Flynn): It looks like he's got something to say.

Make yourselves comfortable. Like everybody else in the presentations, you get 15 minutes. You can use that any way you see fit. If there's a chance you can leave some time at the end for any sort of questions and discussions, we'll try and split that evenly amongst the group, but it's all yours. Relax.

Ms. Christina Jabalee: I think we're going to divide it, half and half. So can we just turn this on so that she's ready to go?

The Chair (Mr. Kevin Daniel Flynn): That will turn on itself, and if you stay about a foot away from them, they work perfectly.

Ms. Christina Jabalee: Okay, wonderful.

The Chair (Mr. Kevin Daniel Flynn): And if each of you would introduce yourselves as you speak so the people from Hansard who know who's speaking.

Ms. Christina Jabalee: Sure. My name is Christina Jabalee; I'll start first. I've kind of written in here who we are, but we'll try to follow along.

We're here to share the story of how our family has been impacted by mental illness and the mental health system. Our brother Michael suffered with mental illness from the time he was 15. Since then, he had times where he was buried in the depths and darkness of depression and, during others, tortured by the paranoia, fear and confusion of psychosis. He lived the agitation, sleep deprivation and chaos of mania. It is with tremendous sadness that I share that Michael is not here to tell his story.

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Michael took his own life last year on July 24 at the age of 25. We are Michael's family. Carol is his mother. She's a mother of three and resides in Oakville. She journeyed with Michael throughout his life and illness, attempting to navigate our system of fragmented mental health care. We are Michael's sisters. My name is Christina and I live in Burlington. I have completed my bachelor of social work and now work as an early intervention family worker for the Schizophrenia Society of Ontario. Jennifer is the mother of my two beautiful nieces and an adorable nephew. They live in Waterloo and she is a family doctor.

We quickly lost confidence in a mental health care system that was unable to provide Michael with the treatment and us with the support that we all so desperately needed. We have come here today equipped with our family's experiences to help you improve our current system. We want to learn from Michael's life and suffering and our suffering so that others will find the help that we did not.

When Michael first displayed symptoms of a potential mental illness at the age of 15, he saw our family doctor. He was exhibiting classic signs of depression. He was sleeping 16 hours a day, not eating, crying a lot and unable to function. There was a six-month waitlist for him to see a psychiatrist so he left that day with no referral, no medication and no further support. His symptoms worsened. He struggled to go to school and dropped out without completing grade nine.

His second attempt to access treatment came at age 17, when Michael had his first manic episode. He was not sleeping. He began working as a roofer, engaging in risky behaviour. His thoughts were racing; he was disorganized and frantic. He fell off a roof and presented to hospital for the first time. But it wasn't until he climbed to the top of the hospital's four-storey parking garage and threatened to jump that he was eventually admitted. Looking back, we are pained with the thought that if he had received early treatment, his illness would not have prevented all the attempts he made to try to have a quality life.

Over the next several years, Michael was in and out of the system, repeatedly treated for brief periods and then discharged without any plan to keep him well. When he was discharged after that first hospitalization he was diagnosed with bipolar disorder, but was provided no psychiatric follow-up. Having been untreated for two years, Michael's mental state continued to worsen. He moved rapidly between depression and mania and first began to experience psychosis. Michael was then hospitalized because he was a risk to himself and others.

After several months in hospital he was discharged with a prescription for an antipsychotic, a mood stabilizer, but no follow-up appointment. The social worker actually copied names from the Yellow Pages and told Michael to find his own doctor. The plan was for my mother to take him to the YMCA. She had to pay his weekly rent for the next two months because Michael had

yet to receive his approved ODSP. Throughout the journey, clothes, food, accommodations were always provided by my mother, even though it was a financial and emotional struggle for her to do so. This became a recurring theme. We are now aware of the significant shortage of psychiatrists and family doctors; however, it is unacceptable for someone to be discharged from hospital without any medical follow-up or community supports. There is a need for improved coordination between mental health services and medical practitioners in order to close this critical gap between in-patient and outpatient care.

As a family, we were constantly at the whim of Michael's symptoms. Our family life revolved around the distress of the illness. We never knew what would be happening next and we lived with a learned helplessness that we couldn't prevent the next crisis. We never received any education about his diagnosis or prognosis. We were left on our own to interpret and cope with Michael's bizarre and at times frustrating behaviours and a system that we did not understand.

Looking back, I am filled with guilt. My patience was worn thin with the symptoms of the illness. I never knew there were other ways for families to cope and respond. I know now, because I facilitate support and education groups for families and see the positive impact it has on their mental health and their relationships. Where was this for us? It is extremely painful to be aware that it wasn't for a lack of medical understanding about mental illness, but a lack of appropriate dissemination of that information that added to our family suffering.

Ms. Jennifer Takacs: I'm Jennifer Takacs; I'll take over from here.

Eventually, Michael's agitated and impulsive behaviours led to run-ins with the justice system. We suffered to see him spend one year in a correctional facility, where he remained untreated and deteriorated. He was targeted by other inmates; once almost suffocated by being rolled in a rug, another time needing stitches for a facial wound, and then protected by being placed in isolation for days to weeks at a time. I would visit Michael with my daughters because it was so important to support Michael and have a relationship with him; he absolutely adored his nieces. These visits were not at all easy. Jail and forensic institutions are not for children, and they should not be for the mentally ill either: They are often equally vulnerable.

When he was released after that year, he was acutely ill. He was paranoid, delusional and hearing voices. He didn't sleep for days. Within three weeks, he succumbed to his psychosis and assaulted a family member and then attempted suicide.

As a family, we were desperate to get him the help he needed. We were advised that he would be best treated in a forensic facility, which meant we had to press charges. Michael was eventually found not criminally responsible and spent the next four years, the last of his life, under the Ontario Review Board.

We were all very close to Michael. We spoke often, sometimes at 4 in the morning. We were always acutely

aware of his mental state. We needed a means to communicate this with his treatment team. However, due to very strict interpretation of the privacy laws, any information that we provided to his treatment team was communicated directly to Michael. Michael was often very paranoid. This pattern made it impossible for us to communicate our concerns about Michael's mental state without worsening his paranoia and causing him to mistrust us.

Paranoia is not a symptom which is unique to Michael. In fact, it is often a prominent feature of psychosis. A mechanism needs to exist for caregivers to give information to treatment teams without these repercussions.

We felt sandwiched between wanting to protect our relationship with Michael and wanting to protect and help Michael. In his last months, we had become so crippled by the poor lines of communication that we could not safely express our intense fear for Michael's safety. Michael took his own life, and we felt powerless to prevent it.

We are left feeling sad, feeling guilty, feeling there was so much more that could have been done, yet feeling exhausted from the years of struggling and now knowing that we didn't have the tools to do more. It hurt to watch Michael suffer, it hurts to live our tragic story, and it hurts even more to go on without him. There is much to learn.

That is why we have come here today. We want to help change a system that made appropriate treatment for mental illness practically unattainable and good mental health for all of us very difficult to achieve.

We are asking you to consider three things: a focus on earlier intervention, more public and family education and better lines of communication.

Early intervention can improve prognosis, lower the burden of disease and, most importantly, improve the quality of life for all those affected. Early intervention is only possible when we are able to recognize the onset of disease and immediately access appropriate treatment and resources. Often that first presentation is to a family doctor, and not only do we have a shortage of family doctors in Ontario, but the resources available to those doctors are severely limited. I require far more than my prescription pad to effectively treat mental illness, and other mental health care workers play a vital role in treatment and recovery.

Family health teams are one such model, where social workers, psychiatrists, family doctors and psychologists can work together. I had the privilege of training in this environment and have seen first-hand the benefits of this model. More family health teams would increase to appropriate primary care, allow for earlier intervention and improve continuity of care upon discharge from hospital. But even more importantly, access to these services needs to be readily available to all family doctors and their patients, regardless of practice model.

In recent years, multidisciplinary early intervention programs for psychosis have become available. They are run as outpatient teams, of which Christina is a partner.

We would like to see these programs expand beyond the diagnosis of psychosis as, in our case, Michael only developed psychosis three years after his first presentation. We need to continue to support these initiatives and increase awareness of their existence.

Secondly, we believe that education of the public and caregivers will work to reduce stigma, increase knowledge and promote a positive environment for early intervention. One such program, for which Christina is also a presenter, reaches into schools and youth groups; it's titled TAMI, Talking About Mental Illness, and is run by the Halton region.

Organizations such as the Schizophrenia Society of Ontario are also equipped to provide numerous resources, including education sessions to assist families. We need to increase the public's and health professionals' awareness of organizations and programs such as these. We should look to these programs as examples of what can be accomplished, and strive to increase their resources and their reach.

Finally, we ask you to strongly consider how we could increase primary caregiver and family involvement in the mental health care system. Families are the private-sector caretakers for people with severe and persistent mental illness. Their involvement is often significantly dismissed.

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Family workers who focus on the specific needs of families are desperately needed. Caregivers and family members are at greater risk of developing mental illness themselves. Supporting families has many benefits.

We thank you very much for giving us the opportunity to share our experience and we very much appreciate your efforts.

The Chair (Mr. Kevin Daniel Flynn): Thank you. We really appreciate you being here today.

You've left some time for questions, which is great. Howard, I think it's your turn to kick off first. We've got about a minute or so each.

Mr. Howard Hampton: It's hard to know where to start, but the overwhelming impression I got is that services were there, but the services were hardly ever coordinated or integrated to work together, and your brother, over and over again, was simply slipping through the cracks. Is that a fair assessment?

Ms. Christina Jabalee: Absolutely.

Ms. Jennifer Takacs: For sure, and I think that would be a fair assessment for a lot of people, not just our brother. I think that's the saddest part of how the system functions. I think Christina said it well also: The services are there, but as you said, they're not integrated, they're not coordinated, and a lot of times, we working in the profession don't even know how to access them.

Mr. Howard Hampton: Do you have a theory as to how this could happen?

Ms. Jennifer Takacs: That's a good question.

Ms. Christina Jabalee: I think often, the services don't know about each other. Now that I'm working in the field, it's amazing to find out who doesn't know

about each other and that even similar programs can be occurring and they don't even know about each other. I think there's just such a disconnect about what's actually going on there. There's no central hub where we all can find this information, and if there is, we don't know about it.

Ms. Carol Farkas: And there's no sharing of the information. You can go from one civic hospital to the next civic hospital; they won't share their records. There is no continuity. They're totally isolated silos.

The Chair (Mr. Kevin Daniel Flynn): Does anybody from this side have a question? Maria?

Mrs. Maria Van Bommel: I just want to go a little bit further from where Mr. Hampton went when you talk about coordination of services. Do you find that in a lot of situations, everybody seems to have a little piece of this and nobody has it all? You know, it's sort of scattered, and part of the problem, like you say, is that you don't even know about each other. But everybody has some sort of a claim to—

Ms. Jennifer Takacs: Every patient or every—

Mrs. Maria Van Bommel: No, no; every agency that has claims that they're delivering some mental health services—but nobody is coordinating that. Even in terms of government funding, we're funding a little bit here, a little bit there, and there's no coordination between any of it so you don't know who's delivering primary types of services and who's delivering more acute or advanced services, or everybody's doing primary, nobody's doing advanced and nobody knows who's doing what.

Ms. Christina Jabalee: Everybody's focused on their area, and it came out clearly with all of Michael's discharges from hospital. There's a social worker, someone who's willing to talk to my mom while he's in hospital, but he's there for maybe three days, a couple of weeks, however long that is. When he gets out, they don't try to link you to a similar service or support. So then you're just dropped because they only know about when he's in hospital. They're not thinking of that continued care afterwards, which is what you would think would happen.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Christina. Christine?

Mrs. Christine Elliott: Thank you very much for joining us today. My question relates a little bit more to your brother's situation. I'm sort of gathering that he wasn't really amenable, necessarily, to treatment, that it was more the family who was trying to get help for him. Is that fair to say?

Ms. Jennifer Takacs: Well, I think it would have fluctuated because his illness fluctuated a lot. Definitely someone who's depressed is often more willing to seek help than someone who's very manic and grandiose and thinking that they've got everything under control. So for sure, I think his illness in general was difficult to treat. At times he would have been harder, so yes, sometimes we were seeking treatment on his behalf. But even when he was willing to take his medication—his mood stabilizer and his anti-psychotic—there was no physician for him

to see. There was no one to renew his prescription. There was no one to support him in his endeavour, to help him find a job, maintain employment or maintain housing. There was a big lack. They would get him stabilized in hospital, he'd go to the community, and then you're basically left waiting for the next crisis.

Ms. Christina Jabalee: One example that we left out of the speech was that three weeks before he died, Michael was so stressed out with his symptoms and hallucinations that he actually took himself to a crisis centre to check himself in, which he never did. He packed a bag and everything. They were so uncoordinated. They had no idea who he was, even though that was his emergency care; he was supposed to go there. Basically, they gave him medication and sent him home. Three weeks later, he dies.

He was so unwell, so that kind of stuff was happening. Even when he was reaching out, the coordination wasn't there. It was both.

Mrs. Christine Elliott: It points to the need for someone to sort of be almost a navigator for—

Ms. Jennifer Takacs: Well, I think mental illness is really a chronic illness. We wouldn't let somebody with diabetes have absolutely no medical care or support. To just treat someone acutely in hospital with a mental illness—and if they need to be there for several months, to just send them out into the community and say, "Find your own doctor with the Yellow Pages"—it's not appropriate. We wouldn't treat people with other medical illnesses that way, and we shouldn't treat the mentally ill like that either.

The Chair (Mr. Kevin Daniel Flynn): Thank you. One final question I had—it just intrigued me out of the whole presentation—is that Michael spent a year incarcerated, you said—

Ms. Jennifer Takacs: Yeah.

The Chair (Mr. Kevin Daniel Flynn): Even during that period he received no treatment?

Ms. Jennifer Takacs: No. He received some—

Ms. Carol Farkas: Epival. A little bit of Epival.

Ms. Jennifer Takacs: He did receive a little bit of a mood stabilizer—

The Chair (Mr. Kevin Daniel Flynn): Just medication—

Ms. Jennifer Takacs: He was given a sedative, but he definitely was not appropriately treated.

Ms. Carol Farkas: Can I say something? At the very, very end of—actually, it sounds like he was a year in one spot; but that's not how it works. They were working him up to Rideau for correction, but he was too paranoid and not able to co-operate. He ended up at the St. Lawrence Valley, which is the psychiatric ward of the jail system. And like they said to me, he doesn't belong in jail.

But basically, again, they don't go to the hospitals; they don't get any prior records. They just deal with the immediate thing in front of them. They gave him, like I said, a little bit of Epival, and when they went to release him, I did get to talk to some social worker, and she said,

"Okay, a little bit of Risperdal." I think it was two milligrams.

Anyway, that's what happened.

Ms. Jennifer Takacs: So he was undertreated, and his illness was under-recognized. I think, at some point, people recognized that he was ill, but he wasn't treated as a patient; he was treated as an inmate, and so he just deteriorated. The whole environment, you could imagine, would increase someone's paranoia and psychosis. He was much, much worse when he left.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today and telling Michael's story. I know that all the committee members really appreciated it. Hopefully some good comes from what you did today.

Ms. Jennifer Takacs: Thank you very much.

NICKEL-A-DRINK FOR ADDICTIONS AND MENTAL HEALTH RESEARCH FOUNDATION

The Chair (Mr. Kevin Daniel Flynn): Our next presenters this afternoon are from the Nickel-a-Drink for Addictions and Mental Health Research Foundation: Lembi Buchanan and Wayne Skinner. Are they here yet? There we go. Thank you for moving up a little bit in the agenda for us today.

Ms. Lembi Buchanan: No problem.

The Chair (Mr. Kevin Daniel Flynn): Like everybody else, you get 15 minutes. You can use that any way you see fit. If there's any time left over, we'll share it like we just did. Thanks for coming.

Ms. Lembi Buchanan: Well, thank you very much for the opportunity. I'm the president of the Nickel-a-Drink for Addictions and Mental Health Research Foundation, and Wayne Skinner is the deputy director for addictions programs at the Centre for Addiction and Mental Health.

Nickel-a-Drink for Addictions and Mental Health Research Foundation was incorporated in July 2007. Our foundation is the only family- and consumer-driven national organization whose mission is to support research activities into the causes of addictions and mental illnesses.

The inspiration for the Nickel-a-Drink initiative is credited to the former US Surgeon General Everett Koop. He asked the question, "Who could quarrel with a nickel-a-drink user fee?" to help pay for alcohol abuse prevention programs and related medical services.

In 2006, the Senate of Canada also recommended that the excise tax on alcohol be increased by a nickel a drink to raise the money to pay for the programs outlined in its report *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada*. According to the report, such an extraordinary measure was necessary because, "Canadians living with a mental illness or substance abuse problem have been neglected, or at best, substantially underserved for so long."

Our provincial government, not unlike the federal government, has a disproportionate dependency on revenues

obtained from the most vulnerable and high-risk consumers of alcohol to pay its bills. Residents of Ontario consume over four billion standard drinks each year, producing \$1.4 billion in dividends from sales of the Liquor Control Board of Ontario and another \$398 million in PST. Not a nickel was spent on research related to the causes and cures of addictive behaviours.

1700

Some 10% of the population consumes more than half of the wine, beer and spirits sold in the province; 20% of the population consumes approximately 75%, contributing \$1.35 billion to the government coffers—and I'm sure you all know what \$1 billion means. These are the people who are the most vulnerable to the harms related to alcohol. Just about all of them would qualify for treatment; however, we do not have an adequate strategy to better understand, prevent and treat problems associated with alcohol abuse. Young people aged 18 to 25, who have the highest alcohol consumption of any group, are especially at risk.

No one denies that drinking is a risky behaviour. It persists even with the knowledge of negative health and social consequences, because alcoholism is a chronic and relapsing brain disease. Despite its profound effect on our society, less than \$10 per person is spent on substance abuse treatment programs.

In December 2008, Auditor General Jim McCarter highlighted how the province is failing some of its most vulnerable citizens. He suggested that up to 90% of those needing addiction treatment might not be getting it, even though the annual economic burden of alcohol and substance abuse in Canada exceeds \$14 billion—that's \$1,185 per person—considerably higher than any of the other disease groups. But there has been no political will to treat addictive behaviours with the same urgency as physical medical conditions. Instead, the revenue from the sale of alcohol is allocated to pay for education, health care and other important government programs and services. The key health priorities in our society include chronic diseases such as cancer, heart disease and diabetes, and we have to remember that alcoholism is a chronic disease as well.

In fact, the slice of the pie spent on addictions and mental health in our province is getting smaller each year. In 1996, 6.9% of the health care budget went to mental health and addictions. In 2006, only 3.3% of the overall health care budget went to mental health and addictions.

Interjection.

Ms. Lembi Buchanan: We're trying to get coordinated here. I just want to talk briefly about the harms of alcohol consumption before Wayne continues this presentation.

Although a glass of wine may be good for the heart, excessive alcohol consumption has a detrimental effect on a number of medical conditions, contributing significantly to the high cost of our health care. Research has already established the complexities of the relationship of alcohol consumption and health outcomes: As many as

60 diseases are adversely affected by heavy drinking, since alcohol affects many organs of the body. Prenatal abuse of alcohol is the leading cause of birth defects, including fetal alcohol syndrome.

Long-term alcohol abuse puts you at risk for developing the following conditions: certain forms of cancer, especially cancer of the mouth, esophagus and the throat, liver disease and heart disease. Alcohol is a central nervous system depressant, leading to reduced work performance, impaired concentration and memory and impaired driving. Every single day, four Canadians are killed on the highways and 200 are injured because of impaired driving. Alcohol also alters brain receptors and neurotransmitters, increasing the probability of aggressive behaviour. Alcohol is often associated with domestic abuse, crime and violence, including homicide and suicide. Nearly 25% of the people consuming alcohol have indicated that they have caused harm to themselves or others when they have been drinking.

Now, Wayne is going to continue on and talk about the current provincial approach to alcohol problems.

Mr. Wayne Skinner: Thank you again for the opportunity to be here, and it's an honour to participate with Lembi, whose work in this area I admire greatly and I'm happy to support.

I just want to talk about Ontario's current approach to alcohol and substance use problems in general. The Ministry of Health and Long-Term Care is the lead in this area. Over \$120 million is spent every year for specialized substance use treatment services in Ontario: a wide range of services, from withdrawal management through community to residential services.

There's a bit of money that is spent on the prevention side, and, actually, the government's investment in research is pretty hard to find. There are places like CAMH, where I work, and other institutions that do research, but our research is funded from other sources, either provincially, nationally or internationally. The balance in Ontario, then, is very much towards treatment funding, but even that, one can argue strongly, is underfunded.

There's a dilemma here, because generally health care costs are increasing. There are priorities that we all recognize and typically they do tend to trump alcohol and drug problems when investments are made. So the issue becomes how to deal with funding alcohol and substance use treatment services, and mental health as well, when you have these other priorities. The solution that we think needs to be considered is looking toward the behaviour itself.

Just generally, it's worth noting that the funding and investment that is being made in this area hasn't kept up with inflation over the past while—Ms. Buchanan mentioned this in some comments—and generally, this tends to be an area that can go to the backburner very easily, even though it insinuates itself into many health problems that we are trying to deal with, some of them ones that we give urgent status to.

Really, the issue, in our view, is that we need to start dealing with this imbalance between the revenues that

society takes from consumers of alcohol—in terms of what the government is getting out of it, and corporate profits as well—and our investment in preventing and reducing alcohol-related harms. That's the dilemma right now.

Essentially, this is, in our view, kind of a key issue, and there is a remedy for this. Rather than having to compete with other health care priorities from general tax revenues, our view is that monies from the consumption of alcohol should be applied to education, prevention, treatment and research of alcohol and related substance use and other problems that apply.

The nickel-a-drink movement is something that this foundation that Ms. Buchanan has set up deals with. If we were to apply across the board a nickel-a-drink surcharge to every standard drink consumed in Ontario—and I don't know if you know what a standard drink is, but we can maybe talk about that later, if you want—it would produce an annual fund in excess of \$200 million. The idea would be not to put it into general revenues but to direct it toward addressing problems related to substance use and abuse in Ontario. That would virtually double the current investment without having to find other sources of government revenue to do it.

The question becomes, can we tolerate adding five cents a drink to the cost of every standard drink? The US Surgeon General quote from a while ago suggests that even then, when a nickel was probably more than it is today, it was not a bad idea. This would be a modest amount to a standard drink. Anybody drinking in a public establishment and giving a tip will give more than that. Probably the cheapest standard drink you could buy would be a 24-pack of beer and that's probably a dollar a bottle.

The idea that this money would be invested back into the prevention, treatment and research of these problems is what we think is the selling point in making a policy initiative like this. The brewing industry didn't face any objections in 2008, when it lobbied for an increase in the floor price of beer. The whole idea of doing this, in our view, is not—there doesn't need to be a barrier. There needs to be some will to act decisively in this area.

There is one area, actually, where there is a policy framework that is worth emulating and that's in the gambling area. The government dedicates 2% of new slot machine revenues and that's how it funds its problem gambling strategy in Ontario. And guess what? That's a much more robust strategy than we have for substance abuse. In Ontario, we pay for treatment; we don't pay for prevention or research. In the gambling area, we have a strategy that pays for a treatment system and prevention, and it also pays for research. That is the direction, we think, that can allow for an innovative response to what I think everybody would agree is an important social problem.

Ms. Lembi Buchanan: So in conclusion, as it stands now, the real winners, from my understanding of the harmonization tax process, are consumers of alcohol. The agreement with the federal government requires the

province to lower taxes on alcohol to a standardized 8% from 12% for LCBO purchases and 10% for beverages consumed in licensed establishments. This is a perfect opportunity for our government to exercise social responsibility by proposing new legislation not only to protect its existing revenue with adjustments to various fees, but also create a dedicated tax levy to close the gap between the cost of the disease burden to our society and the dollars earmarked for addiction prevention, treatment and research, including mental co-morbidities.

1710

People who are most vulnerable to the harms related to alcohol are already providing most of the revenues obtained from the sale of wine, beer and spirits in our province. Therefore, investing a portion of these revenues to address alcohol-related problems makes sense, both intuitively and ethically. The provincial government has already created a similar program, as Wayne indicated, so the precedent has already been set by this government. I understand that it's probably the best program in the world as such in terms of taking an allocation of the revenues from gambling and apportioning it out to various areas.

By adopting this nickel-a-drink initiative, we can make a real difference, not only for the people who are abusing alcohol and drugs but also their families. We will also reduce the economic and disease burden in our society. In your folder you have a copy of an article that André Picard wrote over a year ago about our foundation. He said that if we can adopt this kind of initiative, the end result would be priceless.

The Chair (Mr. Kevin Daniel Flynn): Good time management. Did you hear the beep? That was a wonderful presentation. Unfortunately, we have no time left for questions but I believe the members got your point very clearly. Thank you very much for coming here today.

Ms. Lembi Buchanan: I appreciate that. I didn't really time it with a stopwatch, but—

The Chair (Mr. Kevin Daniel Flynn): That was almost exact.

Ms. Lembi Buchanan: Thank you again.

CHILD DEVELOPMENT INSTITUTE

The Chair (Mr. Kevin Daniel Flynn): Our 5:30 appointment has also agreed to move up. Tony, are you in the audience? If you'd like to come forward, Tony Diniz, executive director of the Child Development Institute. Like everybody else, Tony, you get 15 minutes. Use that any way you see fit. Make yourself comfortable, and if there's any time left at the end, we'll use that for questions.

Mr. Tony Diniz: Thank you, and I hope I don't hear that little beep before I reach my time, because that would be the worst.

Good afternoon. I'm Tony Diniz and I'm here as executive director of the Child Development Institute, which is located in downtown Toronto. I'm also a board

member of Children's Mental Health Ontario and a board member and president of the Child Welfare League of Canada, which has a national focus on vulnerable children and youth.

The Child Development Institute serves the needs of children under the age of 12 and reaches more than 4,000 families and children annually through a range of programs, including healthy child development, early intervention and family violence. Most importantly, I'm really proud of the fact that this year we're celebrating our 100th anniversary and we're looking forward to our second century of service to Ontarians and Torontonians.

I welcome the work of your committee and the opportunity to provide input. There's so much that I'd like to say on the subject of children's mental health, but with the limits of time and the fact that I suspect you'll hear from many others on this key subject, I'm really going to limit my remarks to one area.

The Child Development Institute has a strong emphasis on evidence-based programs and practices. While our programs serve some of the most difficult children and challenged communities in Toronto, we have a core commitment to a scientist/practitioner model where science informs practice and practice informs science. The whole point of this is to increase the effectiveness of our work. Just as we have service partnerships with the boards of education, child welfare and other providers, we have research partnerships here in Toronto with the University of Toronto, Sick Kids, OISE and York University. Further afield, we have partnerships with the Karolinska Institutet in Sweden, the University of Pittsburgh and University of Cambridge, and I'll just mention that Pittsburgh and Cambridge house two of the most important world scientists in children's mental health.

I'm going to speak about SNAP. SNAP stands for Stop Now and Plan. It's an award-winning Canadian model designed by a child development institute to help young children with aggression and conduct disorder who are in conflict with the law. These children are under the age of 12, but well on a trajectory toward serious criminality and violence. The program strategies uniquely marry the education community, children's mental health and police services.

SNAP begins with a protocol to get kids into service; so while they can't be charged under the age of 12, they can't be ignored either. We want them into programs that are going to hopefully improve their lives and their life chances. We have also developed assessment tools to help us understand and measure particular kids. In the third stage, the SNAP program actually helps kids and parents deal with anger. It really teaches kids to stop now and think before you act. I'm sure there are days when all of us could benefit from that, and with a little snap we could make better decisions consistently.

This evidence-based program has proven effective because at its heart, it's simple. It's easy to learn. Kids like it, we can practise it. They can practise their real-life situations that happen on the playground and under-

stand how to manage them in a better way. At the same time, brain research is showing, through imaging at Sick Kids, that SNAP actually alters the brain pattern of the kids who participate in our programs. They start using a different part of their brain, which is factored with control and reason, rather than with impulse and outrage. That's actually showing up on brain imaging. SNAP works through the most rigorous research studies and research is showing us that results stick and are long-lasting.

Now, I'm not here just to tout SNAP. I'm here to talk about evidence-based programs, and not all evidence-based programs are created equal. Because of the strength of the research and the extent of change, SNAP has the highest endorsements. It's achieved exemplary status from the Office of Juvenile Justice and Delinquency Prevention in the United States and exemplary status from the White House's Helping America's Youth. In Canada, SNAP has been endorsed as an exemplary program by the National Crime Prevention Council. Because of this rating, the National Crime Prevention Council is actively funding the rollout of SNAP sites across Canada. This past month alone, we've seen SNAP programs being established in Calgary and in Niagara and, most recently, Minister Peter van Loan announced major SNAP programs in Toronto schools in partnership with Safe School Network. Many other sites and announcements are in the wings.

We have about 100 sites across Ontario and Canada, the US, in Europe and now in Australia. We have two large SNAP sites in Dade county—which is Miami, which has serious juvenile issues—and Pittsburgh, and both are under very close third party evaluation. I have to tell you, we're very proud that a made-in-Ontario solution is being selected as a children's mental health program in many other communities globally and that the replication results are showing the same strong outcome globally as we've demonstrated locally.

In the course of our work, we deal with many jurisdictions that are looking for solutions. We are actively visited by lawmakers—recently from Norway and England; we'll be hosting the minister from Brussels very shortly—and they're looking for solutions. We're on their port of call. They recognize now that science is a key factor in program selection and that the Internet has dramatically sped up access to this information. We see policy- and lawmakers looking for the world's best programs in the same manner that they would look for the world's best-proven medical procedures. We see jurisdictions boldly rolling out children's mental health evidence-based programs at scale, because they know that they have to get the best outcome for their investment. For example, Norway has implemented three leading evidence-based programs, including SNAP, right across their country, with consistency and purpose.

1720

In Ontario, we have recognized in policy documents the importance of evidence-based programs, but I have to say that we're stalled at that point. Language to that

effect appeared in the document *A Shared Responsibility* several years ago, and there has really been no further movement there. It seems to me that we don't have a strategy in Ontario to move this forward.

We can't afford to work this way anymore. We just can't afford to do it. It's the difference between effort and intentions—however well-intended—and results and outcomes. I have to say that trying is no longer good enough when we know we have hard facts and science with which to choose programs.

Ontario is behind other jurisdictions in ensuring that Ontario's children, youth and families have access to proven and best programs. I urge you to include in your report a recommendation that within six months after consultation with stakeholders, Ontario adopt a strategy to transform its funded children's mental health services toward a system of programs that are evidence-based or at least that can demonstrate a level of a promising practice.

Finally, if I may, I'd like to make one other point. Over the course of our research work in childhood aggression, we began to understand some years ago the extent of girlhood aggression and that this aggression looked and was different in some ways from boy aggression. In particular, without intervention, these girls are at high risk for teenage pregnancy, and because of their self-control problems, at high risk for very problematic parenting.

Girls did not respond well to treatment within the same programs as boys, and in fact did worse. For that reason, we formed a separate treatment program called the SNAP Girls Connection program. This program is highly lauded and one of the experts, Dr. James Garbarino from Cornell, calls it the only documented treatment program that works for girlhood aggression.

SNAP Girls Connection has been studied closely and shown to achieve strong treatment outcomes, and has been fully replicated in Hamilton and base-funded by the Ministry of Children and Youth Services. Other replications are now under way in other communities.

Last spring, the ministry convened a conference to draw attention to the issue of girlhood aggression and we laid them for that effort. Our program was in fact showcased at this conference. And yet I have to tell you we have not received a positive response to our request for funding. This is clearly a world-class program, and we have to fundraise annually about \$300,000-plus to operate this program, to the extreme gratitude of about 90 families per year—even though the program is being replicated and lauded across the world. It is confounding for us to achieve any provincial funding, and confounding for us when we talk about the evidence-based programs that we have that are a reality.

I'm pleased to take any questions that are available within the time. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Okay, Tony, that's great. You've left about four or five minutes, which is great. We'll start with Christine.

Mrs. Christine Elliott: Thank you very much. I wonder if I could just ask a question, just to clarify: You don't currently receive any governmental funding, or do you receive some but not enough?

Mr. Tony Diniz: The government funding is for the SNAP boys' program. The girls' program is not funded. The SNAP research has been funded for the last 25 years entirely on foundation dollars.

Mrs. Christine Elliott: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Howard, any questions or comments?

Mr. Howard Hampton: I'm given to ask how a program that has been very successful for boys could just be totally ignored when it comes to girls who manifest the same sort of behaviours. How bizarre. What are you told when you—I mean, you're funding one with foundation money, but you've applied for funding for the other and been constantly turned down.

Mr. Tony Diniz: The response is that the ministry now recognizes the importance of girlhood aggression, but there are no dollars and there haven't been dollars for the four years that we've been asking, even though other programs, including the replications, seem to get funded. So that's what we're told. We've met with different ministers; ministers have come and gone, and we're still left with this situation.

The Chair (Mr. Kevin Daniel Flynn): Liz?

Mrs. Liz Sandals: A very interesting presentation. I'm curious as to what you find the difference is between boy aggression and girl aggression.

Mr. Tony Diniz: There's a common sense that girlhood aggression is passive-aggressive. People understand that in high school, through exclusion and so on—

Mrs. Liz Sandals: It's often social.

Mr. Tony Diniz: Yes. But with the girls we're seeing, it's not the case. The girls we're seeing are assaulting other girls, are beating up girls and teachers, are using pens as knives and actively aggressing. One of the big issues that we find is, with boys, aggression is aggression and it's impulse control. We have discovered that with every girl we've seen, there's a co-morbidity of depression. It's a very different understanding, and what we're finding, too, is that the girls have a very strained, conflictual relationship with their mother. We're not blaming mothers, but we really focus on repairing that relationship because without it, we almost certainly see the teen pregnancy.

Mrs. Liz Sandals: Fascinating, and it's interesting that—I don't want to put words in your mouth, but the more conventional, social aggression that you often identify in girls is in some ways more like physical aggression in boys.

Mr. Tony Diniz: That's right, but we're now seeing the physical aggression in girls as well, though.

Mrs. Liz Sandals: But the physical aggression in girls is a different can of worms than the physical aggression in boys.

Mr. Tony Diniz: Yes it is. When you unpeel it, it is different.

Mrs. Liz Sandals: Fascinating.

Mr. Tony Diniz: And if we don't pay attention to the depression, for example, we're missing half of the issue.

Mrs. Liz Sandals: What we're hearing in so many contexts is that you often have more than one thing going on at the same time.

Mr. Tony Diniz: That's correct.

The Chair (Mr. Kevin Daniel Flynn): Which begs the question: If you treat the depression, does the aggression go away automatically or does that need to be treated as well?

Mr. Tony Diniz: We treat them both. Aggression has to be treated with self-control. The girls have to learn that there are better ways to express anger. Many girls see family violence and believe that physical aggression is a way of expressing interest, handling conflict, many other things, so they have to learn different solutions. It doesn't work in school; they have to learn to find other ways.

The Chair (Mr. Kevin Daniel Flynn): Tony, thank you very much for coming today—a very interesting presentation. As with the previous presentation, hopefully you did some good for yourself today as well.

DIANE SACKS

The Chair (Mr. Kevin Daniel Flynn): Diane Sacks has joined us early. If you'd like to come join us at the table here—there should be some clean glasses left there, and some water. Make yourself comfortable. Everybody gets 15 minutes. You can use that time any way you see fit. If there's any time left at the end, we'll just get into a discussion with the three groups.

Ms. Diane Sacks: Good. Thank you very much. My name is Diane Sacks. For over 35 years now, I've practised pediatrics and adolescent medicine, both at the Hospital for Sick Children and, more recently, at North York General Hospital. I have a private practice in pediatrics in North York.

I'm wearing a number of hats. One is the Canadian Paediatric Society's; I'm chair of their mental health task force. I'm a member of the child and youth advisory committee of the federal mental health commission. I'm also, of course, wearing a hat as a community pediatrician and other primary health care providers who see and try to help in the valiant and never-ending battles fought by our patients and their families as they try to get services, both health and educational, for these children over the young years.

It's important, when the government is trying to organize a health care project, that we start with some of the facts we know. We just heard about science and mental health, and it has gone leaps and bounds in the last 10 years. I hope I'm not repeating what other people have said. What we know is that more than two thirds of mental health disorders begin under the age of 25. We know that one in five youth in Ontario—and that's under the age of 18—has a diagnosable mental health disorder, whether it's anxiety, depression, eating disorders, ADHD, autistic spectrum disorders. And we know that, of this group, less than one in five ever get to see a health

care professional. Those are firm numbers, replicated many times.

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We also know that whether you get help or not is determined largely on whether you can pay. I would like to tell you that nowhere is the two-tier system of health care more alive and well than in the area of pediatric mental health. We know that early diagnosis and treatment may substantially improve outcomes because, just like in cancer and diabetes and other medical problems, delay in diagnosis and treatment can result in terrible secondary consequences. This is more than true of children with mental health disorders.

For these children, having mental disorders stops them in their tracks and keeps them from the normal developmental parameters of successful adolescence into adulthood. They're isolated. They lack social skills to form peer relationships. Often, if they have peers at all—and this relates directly to Tony's comments—they are forming toxic relationships with kids estranged like themselves. For men, we call these "gangs." For the girls, I guess they're still groups, but they are girl gangs.

Many of these young children with undiagnosed mental health disorders are so anxious or depressed that they can't concentrate, they cannot attend school regularly, they fail and even drop out. Schools don't have to look any further for reasons for failure or drop-out than the mental health situations of these patients who are leaving.

Another, secondary consequence of an untreated mental disorder is substance abuse. Substance abuse is not necessarily a problem, but, in fact, it's a teen solution to a problem. Mental health is not being addressed, so they self-medicate. Substance abuse is the solution, not the problem, for many of these teens.

We have learned through neurophysiology that critical brain growth does not stop at age three. In fact, adolescents show tremendous brain plasticity, so treatment at this stage is particularly crucial. These disorders keep children and youth, as I said, from progressing to be healthy adults. Some—too many—don't make it to adulthood. They are affected by these secondary consequences of untreated mental health, and depression becomes comorbid.

What happens is, depression is the leading underlying factor of suicide in Canada, and suicide is the number two killer of adolescents. Having worked with adolescents for 35 years, I can tell you it's probably number one. Kids who are depressed take alcohol and get in a motor vehicle—which is number one—specifically for the purpose of killing themselves. It's listed as a motor vehicle accident, but in fact, it's a suicide.

What can we do? We know now that there are well-validated, well-researched assessment tools to diagnose mental health disorders in children and youth. We know how to identify children and youth who are at risk for mental health disorders. Primary health care providers are very well placed to educate and monitor these disorders that run in families. The number one underlying risk factor for having depression or anxiety is having one

parent with depression and anxiety. So the family doctor knows or the pediatrician takes a history and finds out: "This is a kid who needs to be followed and watched." Thirdly, and most importantly, we know that there are effective treatments—up to 85% in such cases—both non-pharmacologic and pharmacologic, to help these children and youth to continue their paths to successful adulthood.

We know that there are a number of college-regulated professional groups who can treat children and youth with mental health conditions but are not accessible because their counselling is not covered. We know that publicly funded services for these conditions are seriously underfunded and leave families scrambling for the few spaces available. We're not even close to the number of child and adolescent psychiatrists in Ontario to assess or offer continuing care to those who need treatment. Presently, primary care doctors are not properly prepared or remunerated for counselling these patients and their family. The total number of child and adolescent psychiatrists in Canada is under 500. I tried to find the number for Ontario; I really couldn't.

We know that there are huge silos that have separated mental health providers, both educationally and geographically, from the rest of the medical system. This isolation of mental health services does not bode well for patients, their families or providers because, "I'm not familiar with who's doing what. They're over in a different area and I can't reach them. I don't know about them, and I can't reach them."

We know that children's mental health services are even more fragmented than those for adults. Case managers and organizations arbitrarily make decisions about when to transition these patients on, a decision which is often, by the way, made and which makes no sense. Although the majority of mental illness begins before age 25 and needs to be effectively and intensively treated during this time, there's an abrupt interruption of child services between the ages of 17 and 19. Therefore, the services are interrupted at a crucial time. We need these services to go through those adolescent years to at least age 25.

Don't forget, most of these youngsters are developmentally and socially delayed because of lack of schooling and lack of a peer group. Although they may be 20, that's not where they are developmentally, and yet—boom—their services are cut off because they're 18.

We know the case management system—important for patient and family support—needs to be majorly improved for these children. It's no wonder patients and their parents are exhausted under the current system, as they have to reapply year after year after year for the same services, even though it's apparent that the condition is unchanged. These applications really become a full-time job for families. They can't work and do these applications.

So what can we do with it, and how can we address some of these problems?

I recommend targeted, province-wide screening in schools for high-risk groups. In this vein, there will be

appropriate tools and programs, mostly web-based and community-dependent; the community will choose what's appropriate for them. It will be available in less than two years, as we're working on that in the child and youth advisory committee for the mental health commission. There's a school-based mental health project. It's going nationwide; there's a lot of contribution from Ontario. We will have programs where some school may say, "Hey, that looks good for us; it fits," and so maybe they will try it. This is going to be available, but we have to fit it into the school system.

I recommend expanding health coverage to college-regulated professionals who treat children and youth with mental health disorders. We have found, especially with the new treatments—cognitive behavioural therapy, it's a non-drug treatment that everybody loves. It can be used by doctors, psychiatrists, psychologists, social workers, teachers, nurses and, unfortunately, even a computer. When they test them, the success rates are quite good. I knew I was going to be replaced sooner or later by that thing, but it's sooner.

I really recommend physically moving mental health services into more primary care settings, where a lot of the assessing and educating of families can actually be done by the primary providers. Mental health monitoring should be an incorporated, even a required part of the Well Baby Well Child visit. As the medical profession, we need to encourage primary health care providers to establish ways—and, yes, be compensated—for dealing with mental health disorders. It's easier to treat a sore ear or a throat than to sit down and wait for a teenager who barely talks to try and tell you what's wrong with them and what's hurting.

I think by increasing competencies of different professionals here, some primary providers could really treat many mental health issues. With close interaction and education with mental health professionals for backup and consultation, the line for children and youth with complex or serious mental health disorders would shorten dramatically. That means we need to compensate child and youth psychiatrists for advisory positions with these professionals and other health care professionals, and it must be enhanced, whether that's by computer or telephone; we need to really spread that program.

I recommend completely revamping case management systems for these patients and families and using modern technology. Waiting for a face-to-face meeting with some of these people can take months, during which time a child can definitely spiral downward enormously.

The status quo—and I'm just repeating what David said—is really not an option. Continuing to identify and trying to treat these patients as adults is not a viable option. The loss to our society of thousands of these children and youth is unacceptable, both ethically and financially.

Thank you.

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The Chair (Mr. Kevin Daniel Flynn): Thank you, Diane. You have left some time. Let's start with Howard.

Mr. Howard Hampton: You actually strike a few tones of optimism there.

Ms. Diane Sacks: I hope so, otherwise I would have given up a long time ago.

Mr. Howard Hampton: Let me ask you this: Given the array of services that are there—and those services are not perfect; I think we heard you there. There is an array of services, but I think what I hear you saying most of all is that they're not used appropriately. So what's the single biggest thing you think needs to be done that would make the single biggest difference?

Ms. Diane Sacks: The services are not necessarily not used properly, but, in fact, they're not initiated properly. We have learned—it took medicine a long time—these services need to be patient-directed if they're going to have any appropriate impact for families and youth. That means there has to be somebody who knows—a case manager; as I said, whether it's a history that's on a computer that continues and follows with this family, but I think if we got case management directed by the patient and family—what works for them. What works for someone in Toronto won't work for someone in another part of Ontario, so we need to listen more carefully.

There are very few areas where we have great histories on these children and youth, and so we need to pick these kids up early and we need to support the families early. Then we need to transition so these youngsters know how to support themselves. They can be more resilient than those who don't have mental health disorders because they've gone through this and they know how to cope. These can be amazing individuals, but they really need support to learn how to cope through these various stages. So I think patient-directed and one-on-one case management, at some level.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Diane. Any questions from this side? Liz?

Mrs. Liz Sandals: So if a child or youth comes into your office and you start to work with them—albeit not that you have a whole lot of time—and you realize there's a mental health issue, what would you be doing in your practice? What steps would you go through to try to figure out the service and to connect them to service?

Ms. Diane Sacks: The first thing you do is you need to assess. Primary care people can do this very well. Then we need to diagnose, and you can do that very well. Then you need to establish how sick that individual is. If they are mild, there is nothing stopping, except time, a primary care practitioner from instituting very basic, cookbook cognitive behavioural therapy, which works 65% to 85% of the time for these mild individuals. I wrote guidelines along with the University of Toronto and Columbia University for the taking of primary care treatment for kids with depression called GLAD-PC. Step by step, it says this is what you do in the first visit, this is what you do in the second visit. It explains specifically when you refer to a secondary psychiatrist or psychologist for further evaluation. That can be done after. GLAD-PC says, "Okay. You've had two or three weeks. Nothing's happening or the youngster's getting

worse—more suicidal—on your questionnaires, which are included in this program, but they need time." Right now, when I present this—and I've gone all over the country presenting these programs; we have one for anxiety, we have one for depression—the doctors say they don't have time. They don't have half-hour or 45-minute slots. They would if they were paid for it. I know that's—

Mrs. Liz Sandals: I understand what you're saying.

Ms. Diana Sacks: I'm one of the fortunate doctors who has a working husband and he supports me. I'm just not supposed to charge him for anything I do in medicine. But the truth is, I have time, but a lot of family doctors don't. I've tried to convince them to take an afternoon and see three or four of these kids, but if the mental health professional was in proximity to the primary care provider, they would learn how to do this quickly. When you do something over and over you can be more efficient with your time, and it could only take a half hour. Many of these kids can be helped with supportive counselling, as well as some cognitive work, with a minimum of time.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Diane. Christine, a brief question?

Mrs. Christine Elliott: Just a brief question. I'd like to thank you very much. You've left us with a lot to think about here.

One thing I was interested in—because you're the second person today who has commented about the high relationship between children with mental health problems and parents with mental health problems, how do you approach that with the parent, when the parent might not necessarily realize that they have a mental health problem too?

Ms. Diane Sacks: Of course, that's where the primary health care practitioner comes in. It's also where the hat I'm wearing with the mental health commission will come in. They are going to have a very large anti-stigma campaign, which we hope will let people know that mental health disorders must come out of the closet. I think there are a lot of reasons—there are a lot of barriers to that. I think the main one is that people don't think that there's help, or that the help will come in the range of a medication that will zombie you. So there's a lot of education that needs to be done.

I think we have a captive audience, because parents will do an awful lot if they know their children can be helped. So although they say, "I don't want you to write on my chart that I have depression, because my employer might ask you for my records or something," if you tell them this is essential for their kids—so you need to know that so-and-so was an alcoholic or you need to know that someone in the family dropped out of school and he really had great potential so we don't know what happened. That's a very important piece of history. These kids can be picked up and followed so we can catch them early or give them tools before they get sick.

I don't know if you know a lot about cognitive behavioural therapy. It's wonderful for everybody. Everybody should do it.

The Chair (Mr. Kevin Daniel Flynn): Thank you. I wonder if you could briefly answer one question that just entered my mind and that is, from a clinical perspective, why are “anxiety” and “depression” almost always used in the same sentence?

Ms. Diane Sacks: They’re co-morbid in about 30%, and you could put down anxiety, depression and ADHD. If you have anxiety, you have a 30% chance of getting depressed. If you have depression, you have a 30% chance of having diagnosable—on questionnaires— anxiety, and the same is true with ADHD, for some reason. We know the reason: They’re actually very close genetically. We have the genetic outline for a lot of these disorders. They seem to be in the same place.

The Chair (Mr. Kevin Daniel Flynn): Thank you for coming today.

Ms. Diane Sacks: I’m sorry I’m so long-winded.

The Chair (Mr. Kevin Daniel Flynn): No, that was wonderful. You gave us some wonderful—

Ms. Diane Sacks: I’ve left an H1N1 office, so I’m so happy to be here.

The Chair (Mr. Kevin Daniel Flynn): Thank you for coming. It was really appreciated.

And we’re adjourned. I understand there will be a vote shortly.

The committee adjourned at 1744.

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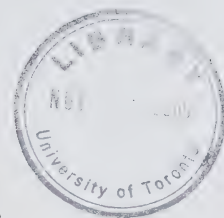
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Select Committee on Mental Health and Addictions

Mental Health
and Addictions Strategy

Comité spécial de la santé mentale et des dépendances

Stratégie sur la santé mentale et
les dépendances

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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

SELECT COMMITTEE ON
MENTAL HEALTH AND ADDICTIONSCOMITÉ SPÉCIAL DE LA SANTÉ
MENTALE ET DES DÉPENDANCES

Wednesday 4 November 2009

Mercredi 4 novembre 2009

*The committee met at 1604 in committee room 1.*MENTAL HEALTH AND ADDICTIONS
STRATEGY
ONTARIO LONG TERM CARE
ASSOCIATION

The Chair (Mr. Kevin Daniel Flynn): Okay, if we could all take our seats and get the meeting going. Our first delegation today is from the Ontario Long Term Care Association. If you'd like to come forward and make yourselves comfortable at the end here, there's some water and glasses there. Thank you very much for coming today. Like all delegations, you get 15 minutes. You can use that any way you see fit. If you'd leave some time at the end for questions that would be good, and if you would introduce yourself the first time you speak for Hansard, then they'll know who they're listening to. It's all yours.

Ms. Christina Bisanz: Thank you very much for the opportunity to be here. My name is Christina Bisanz and I'm the CEO of the Ontario Long Term Care Association. With me is Nancy Cooper, who is our director of policy and professional development. We're pleased to have the opportunity to share with you our thoughts on the role of long-term care in mental health and addiction.

We certainly believe that long-term care can be a part of a system mental health and addictions solution for the aging population in Ontario; however, it can't happen by default. The existing structure that specializes in dealing with the health impact of aging, including dementias and behaviours, is only the foundation. The solution requires the addition of strategic initiatives and resources.

Ontario's long-term-care sector is considerable: over 600 homes in the province, with 76,000 residents and upwards of 80,000 staff. Our association, OLTCa, represents the charitable, not-for-profit, municipal and for-profit providers for some two thirds of this sector: 430 homes, with 50,000 residents and an equal number of staff. Our members provide highly specialized services that help residents manage the increasingly complex physical and mental health impacts of aging with comfort and dignity.

For the past decade, over 60% of long-term-care residents have been diagnosed with dementias, primarily Alzheimer's. With the aging population and people living longer at home, long-term-care homes have now been

noting increased acuity in mental health conditions both upon and following admissions. This is starting to show up in the data, including the resident assessment data that is now becoming available with continued implementation of the MDS care planning system.

For example, recent data has shown that 26% of residents reported signs of worsening depression over a three-month period; 13% were deemed to be at high risk for serious mental health or behaviour issues; and 2% had previously been in a psychiatric hospital.

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Homes are being challenged by these trends. Other data showed that 49% of homes reported having to call the police for assistance, and 46% reported having to use a form 1 and/or associated psychiatric leave. There's no doubt these challenges will increase.

In the US, where long-term-care trends often appear some 10 years before what we see in Ontario, we're noticing:

- middle-aged persons with schizophrenia now have an almost four times greater risk of admission;

- symptoms of depression in persons over 65 are the single indicator of likelihood of admission; and

- in the period of 1999 to 2005, the proportion of admissions with mental illness overtaking the proportion with dementia.

Clearly, both the expectation and reality is that long-term care will play an increasingly larger role in the health system's response to aging, mental illness and addictions.

This is a daunting yet hopeful challenge. The hope lies in how we can strategically build on our existing foundation and, in particular, four key elements.

The first element is the solid core of specialized training. In 2007, some 80% of long-term-care homes had PIECES-trained registered staff on two of their three care shifts. PIECES is the Ontario-developed, best-practice approach for individuals with complex cognitive and mental health needs. In almost half the homes with behaviour and/or dementia units, 75% of unregulated staff were trained in the U-First program, which is a complement to the PIECES training for nurses.

The second element is the recognition of the need for, and the development of, partnerships between homes, hospitals, psychogeriatric outreach teams, community agencies and other health care providers.

For example, in 2007:

—80% of homes with special care units had access to external psychogeriatric resources for at least one shift per day;

—94% of homes reported liaising regularly with the provincial network of psychogeriatric resource consultants; and

—64% of homes reported using additional community resources.

The third element is the promise being shown by individual mental health pilot initiatives. For example, McGarrell Place in London is partnering with a hospital outreach team from St. Joseph's to provide care for residents who were former in-patients of provincial psychiatric hospitals. Another one of our homes, in Cornwall, is partnering with a local psychogeriatric outreach team and a psychogeriatrician who conducts assessments and prescribes interventions for dementia and difficult behaviours. And the Toronto Central LHIN's mental health partnership is focused on providing effective care within the home, to avoid transfers to hospitals wherever possible.

The fourth element is the early indication of success. The results of a 2009 survey by the regional geriatric program showed that 28% of homes reported a reduction in transfers to emergency as an outcome of education and training, and 64% of homes reported a reduction in the incidence of injury to staff and residents.

The challenge now is to build on this foundation, which, although promising, remains fragmented, inconsistent and incomplete. In so doing, we need to reiterate that this promise is not as a system panacea. Instead, it is one component of a system solution that recognizes and supports the role of long-term care and the specialized population it serves within that system.

In this context, we leave you with the following recommendations:

(1) There must be an effort to comprehensively and consistently address mental health and addictions issues and opportunities across the full long-term-care sector as part of a provincial system's approach. Let's bring together what is already happening, strengthen it where appropriate and fully integrate it into a system solution.

(2) We must increase and strengthen the partnerships between homes and dedicated external mental health resources across Ontario. There must be consistent equity of access for residents of all homes to these specialized resources on both a routine and urgent basis.

(3) Homes must be supported to strategically add the specialized resources required to ensure consistent access to best-practice-based care within the home. This may indeed lead to more and/or increasingly specialized units for both higher specialized care and to enhance safety for all residents and staff. We caution, however, against the focus on a structural solution only. The term "specialized" must be taken to equally mean the appropriate space and the appropriate care resources.

(4) There must be a renewed emphasis on, and support for, ongoing formal education and training for all long-term-care home staff. This includes registered and un-

registered staff and recognizes the reality that staff work as a team to meet the full needs of the resident in a care setting that is the resident's home.

The evidence clearly demonstrates that formal education and training for all staff drives positive outcomes. We believe these initiatives will serve to build on the progress that is being made in long-term care. They will strengthen our sector's capacity to work effectively with our health care partners as part of a mental health and addictions system solution.

Again, thank you for the opportunity to present to you today and we'd be more than willing to answer any questions you have in the time remaining.

The Chair (Mr. Kevin Daniel Flynn): Perfect. Thank you, Christina. You've left lots of time for questions. We've got about two minutes for each. Christine or Sylvia?

Mrs. Christine Elliott: I'd just like to thank you very much for coming to present today. I think you've raised excellent points for consideration, and certainly it's consistent with what we've been hearing from some of the presenters in some of the different jurisdictions we've been in, so thank you.

The Chair (Mr. Kevin Daniel Flynn): Sylvia, did you have anything? France?

M^{me} France Gélinas: I'm looking through some of the recommendations that you've made. Have you costed out any of the solutions that you've put forward, as in making sure that every one of the 80,000 staff has had the new training, etc.?

Ms. Christina Bisanz: Not directly, no.

M^{me} France Gélinas: Do you have any sense of how far from there we are?

Ms. Christina Bisanz: Well, we do have a sense of how far we are from fully and adequately resourcing long-term care as it currently exists. So this would be an incremental cost and we would be happy to go and conduct an analysis of what more education, training and support services would involve.

M^{me} France Gélinas: All right. That's okay. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you, France. Liz?

Mrs. Liz Sandals: Thank you for your presentation; that's very helpful. I think in many cases we have the perception that long-term-care residences deal with people with Alzheimer's or other dementias and that can lead to behavioural and other issues, but what you really seem to be identifying here is that you're seeing an increasing population which has actually got a mental health diagnosis as opposed to an Alzheimer's diagnosis. Could you tell us a little bit more about that and why you think that is or what impact that has in a different way of having to manage the resident?

Ms. Nancy Cooper: I think we'll see more and more. When the data comes out from the rollout of the minimum data set we'll have much better information. What we're finding is that, traditionally, we only thought about Alzheimer's and it not being connected to a variety

of mental health issues, and we're beginning to understand there is that linkage.

The other thing is that there's a little bit of ageism in the approach to the elderly, and assuming that, as you age, you will normally become depressed. Very clearly, the evidence is showing that is not the case, that it's actually a mental health issue. I think the fact that we have better tools means that we're getting a better sense of what the resident needs and we're better able to pick up the differential diagnoses and the impact of what type of care we need to provide.

Mrs. Liz Sandals: Thank you very much.

The Chair (Mr. Kevin Daniel Flynn): I had one question. The training that somebody who is a psycho-geriatrician needs: What would that be?

Ms. Nancy Cooper: They are psychiatrists who are specifically trained in geriatric psychiatry.

The Chair (Mr. Kevin Daniel Flynn): But they have the same training as a psychiatrist; they just specialize in geriatrics.

Ms. Nancy Cooper: Yes.

The Chair (Mr. Kevin Daniel Flynn): Very good. Thank you very much for coming today. It's really appreciated.

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JOANNE PURDON

The Chair (Mr. Kevin Daniel Flynn): Our next presenter today is Joanne Purdon. Is Joanne in the audience? Joanne, if you'd like to come forward. Good to see you. Please make yourself comfortable. I think you were here at the start. Everybody gets 15 minutes. Use that any way you see fit, and at the end, if there's any time for exchange, that's always good.

Ms. Joanne Purdon: Okay, thank you. My name is Joanne Purdon. I'm a family member and primary caregiver to my nephew, who's 24 years old and lives with schizophrenia. This is my personal story and my observations along the way.

The Chair (Mr. Kevin Daniel Flynn): Joanne, you just did exactly what I was going to ask you to do, which was to pull the mike down.

Ms. Joanne Purdon: Okay. Is that better?

The Chair (Mr. Kevin Daniel Flynn): Yes, that's perfect.

Ms. Joanne Purdon: Okay. When my nephew was 12, his mother—my sister—passed away. He and his two younger siblings began living with his grandmother, who is my mother. From the beginning, I was involved in helping my mother raise the children.

When my nephew entered grade 9, he started to socially withdraw, with decreased motivation, concentration, sleep and behavioural changes, loss of function in school, problems with anger, anxiety and lower energy levels.

We had countless agencies and school counsellors attending the house, talking to him from the other side of the door. He started to get involved with the law—small,

petty offences with other schoolmates, which soon escalated. He was diagnosed with conduct disorder.

After a suicide attempt at 17, he was referred to a youth psychiatric unit of a major Toronto hospital. They diagnosed him with depression and he was discharged two weeks later with a prescription for antidepressants. This was the beginning of what is known as the prodromal stage of schizophrenia. Prodromal refers to a period of decreased functioning, disturbances to thinking and other problems prior to the first psychosis or the onset of schizophrenia:

"The timing of onset of psychosis is usually in adolescence or young adulthood when personality development and identity issues are still being resolved. Deviant behaviour during this period of untreated, unrecognized and misunderstood psychosis may cause a potentially threatening crisis such as aggressive and suicidal behaviour. Increased use of substances may all occur at this time. Effects are not only felt by the individual but by the family as well ... clearly minimizing the delay between the onset of psychosis and treatment can reduce this psychological, social and possibly biological disruption."

Six months later, my nephew had a full-blown psychotic break and was incarcerated in the Don jail, just weeks past his 18th birthday in 2003. This was the beginning of my involvement with the mental health system. I posted his bail as his surety, and one of the conditions was that he would obtain medical and psychological help.

When he was released into my custody, he stated that he needed medical attention. He was emaciated and dehydrated. Once at home, I soon realized he would not eat or drink anything. He said to me he thought he was losing his mind. This was the last time he would have any insight into his illness until 2007.

Over the next few weeks, I tried to get him help. I spent 18 hours in the emergency department of a major Toronto hospital trying to see the on-call psychiatrist and social worker. He hadn't eaten or drank anything other than a sip of water in weeks. His blood pressure dropped from 120 to 80. Not only did he require psychiatric help, but also medical intervention. He was difficult, but he was experiencing his first psychotic break and was paranoid. He was not admitted and I left with him 18 hours later. There was no referral and no one discussed anything with me due to the privacy issues; I was a "family member."

The comments I overheard from the staff in the emergency department were disheartening and hurtful. This was discrimination and stigma from professional health care providers. I was shocked. I expected this from the general population but not from professional health care workers. I also experienced stigma and discrimination from municipal and government employees as I navigated the mental health system in later months pertaining to my nephew, and I was even called at work and yelled at: "Who do you think is going to pay for this legal aid invoice?"

We have to choose what is best in the course of treatment for our family members who suffer from a serious mental illness. Many battles are left behind as we cannot jeopardize the future quality of care we require for our family members.

Two weeks later, he was admitted to the first-episode unit at the Clarke for about two months, but not long enough to be stabilized for someone with a serious mental illness, who refused to eat and had lost well over 45 pounds, and was curled up daily in a fetal position. His bones protruded out all over his body. He was emaciated and his cheeks were hollow.

He was given a drug called Zyprexa. The weight gain from this antipsychotic drug can be anywhere from 100 to 200 pounds. There was only one family meeting with his nurse and psychiatrist, and a brief telephone call to me stating he had been diagnosed with schizophrenia.

We were notified almost the day he was being released and that he would be followed by the HIP team in the community. We, as a family, were unprepared and given no advance notice prior to his discharge from the psychiatric unit. No one gave us any information about what to expect, here's what to do and how seriously ill he actually was. I only knew what I had heard, that people with schizophrenia, when they take their medication, do well. What I did not know is that the medication has to be appropriate and fine-tuned to that person's body chemistry.

We were left to navigate the system by chance. Families need training about how to respond to unacceptable behaviour, when to let go, when to draw the line. For me, personally, I couldn't have gone through this without family peer support. This is where I learned of available programs and newer and better medications.

He was transferred from the HIP team to the ACT team in the community and placed in supportive housing, which was found for him shortly thereafter. A sudden change in medication was made and the daily dose was greatly reduced. He was on a clinical study so that they could administer an injectable medication. According to the terms of the study, he was given a minimum dose to start and it would be raised accordingly. He became extremely psychotic, delusional and was hallucinating. This would mark the beginning of many hospitalizations, suicide attempts and ongoing trouble with the law.

At this point, he should have been admitted to a psychiatric hospital by the ACT team to be stabilized and given another anti-psychotic medication. I was advised by his health care provider not to let him in my home when I was alone and only to see him in a public setting. During this period, I took a week's vacation. I had my nephew admitted to CAMH, where he was formed. His case was taken before the Consent and Capacity Review Board and I was not notified. He was then released back into the community.

My nephew didn't last long in supportive housing. An eviction notice was obtained against him due to noise and conduct disturbances. When I first met with the manager of this supportive housing unit I was told that we were

unable to fight the eviction order. At the entrance of the building I noticed many eviction orders pinned to the corkboard. I attended the housing tribunal to fight the eviction. When I spoke to duty counsel, they expressed that this was a regular occurrence; even those who did not create noise but maybe were late with their rent due to symptoms of their illness were being evicted. They seemed to be shocked at the number of people being evicted, especially since supportive housing is supposed to be for people with mental health issues.

There is much discrimination faced by people with psychiatric disabilities in supportive housing and the stigma is great, so that they are often given misinformation by management: "You're unable to fight this eviction order. One more complaint and you are out."

Many do not know their rights, and having a mental health disability often creates fear in people, and so they are unable to fight the notice or file a complaint. These supportive housing units are funded by the Ministry of Health and Long-Term Care, yet people are discriminated against based on disability.

How do we accommodate people with a serious mental illness? Evict them out on to the street or shelter and hopefully the ACT team will find them to maintain treatment or, in the alternative, family members are again left to pick up the pieces. There is a need for appropriate supportive housing, and sometimes many of the alternative living conditions are unsafe.

There is all this talk about putting people into the community who are to be followed by the ACT team, but sometimes the situation calls for hospitalization, and it should be made available. When people are seriously ill, they require professional care. They should not be evicted based on health-based discrimination. They should be getting appropriate treatment in a hospital setting or appropriate supportive housing that should be made available to those who require more supervision, care and understanding.

To be followed in the community creates risk for both the consumer and family members who are ultimately left to pick up the pieces. We are leaned upon to care for our relatives as case managers, provide treatment support, crisis intervention and advocacy, monitor symptoms and support in place in case of a relapse, and maintain records of treatment and hospitalization. For us, this is 24/7 and we cannot go home at the end of the day.

The important roles that family support can play in recovery from mental health and addiction problems are well documented. These roles and our value have been recognized by professional groups and government bodies, yet, despite that, we, as families, find that our observations and our opinions are rarely sought. We, as families, contribute significantly to the care of people with mental health problems and often at a personal cost.

Once my nephew was evicted, he was referred to a hostel, not a group home and, again, numerous visits to the emergency room as he was psychotic and suicidal. The 20 or so voices were overwhelming to him and he was hallucinating and delusional. On one occasion the

emergency department released him back into the community even though he said he was suicidal and had been for three weeks or so. On a few occasions, he was released back into the community with over a week's supply of medication in hand that he ingested, and we were back into the emergency department to deal with an overdose. On one occasion, the emergency department on-call psychiatrist thought it would be more cost effective to have him followed in the community by the ACT team rather than to admit him.

1630

Prior to this medication change, I had advocated for my nephew to be put on clozapine and accepted into the STEP program at Whitby Mental Health Centre. Over the past three years, I was constantly discouraged. He was only given older and less effective anti-psychotic medications. Sometimes even the whole half of his face would droop and his tongue would hang out, off to the side of his face. He felt that the whole side of his body was affected and had trouble walking. These were just a few of the many side effects. I was told not to worry. He was hitting rock bottom on the street, living in a youth hostel, on medication that did him absolutely no good.

He was still so young. Why would no one give him a chance? Why was he not eligible for better and effective medication, such as clozapine? I had heard all the stories in my peer support group of how well people with schizophrenia had done on this drug. Why was he not worthwhile enough to be given a decent chance for recovery? Why would he not be eligible for the STEP program, where they would administer the drug over a six-month period?

I was starting to lose faith. I questioned how long I could go on advocating tirelessly, with absolutely no positive results. It seemed overwhelming. I thought that maybe I should move out of the province, as I could not witness his slow descent into madness and his probable outcome.

Finally one nurse from the ACT team—and that was all it really took—helped to get him accepted into the Whitby Mental Health Centre STEP program, where he would be eligible for clozapine. They were discouraging about his admittance to the program, but the nurse convinced them and he was accepted into the program.

His stay in the STEP program was 11 months, and his one-on-one psychiatric nurse from the STEP program advocated to have him stay, as he felt he was not stable enough to be discharged. The STEP program educated him about his illness and how to troubleshoot his symptoms and taught him life skills.

The numerous suicide attempts, trouble with the law and self-medication are all things of the past, and so are his psychosis, delusions and hallucinations. He was so tormented and agitated by voices and hallucinations. He was released from the Whitby STEP program in February 2007, and to date has not had one hospitalization or been involved with the criminal justice system. He is 24 now and finally stabilized, due to two psychiatric nurses who went above and beyond their call of duty.

His cognitive functioning level has been affected as the psychosis was not addressed early enough, wrong medications, a clinical study in which the amount of medication was so reduced, to a minimal amount, and/or a placebo was used that resulted in full-blown psychosis. With each and every psychotic break, the recovery outcome is lessened. Stabilization will take much longer and the cognitive functioning level will be affected.

But to date he does continue to improve slowly and steadily. We see improvements all the time. Thankfully, he doesn't hear those negative haunting voices anymore and has a quality of life. He can actually sit down and watch a movie from start to finish, without all the distractions going on in his mind. That was one of the first things he said: "I can finally sit and watch a movie to the very end." He has his hobbies, music, video games and his friends like any young man of his age.

My recommendations are as follows:

(1) Early intervention: Treating symptoms during the prodromal stage to reduce distress and disability and risk of a more serious condition. We need to educate teachers and counsellors to recognize the early symptoms regarding mental health issues and make the appropriate referrals.

(2) Reduce stigma and discrimination from the professional health care providers.

(3) Access to all appropriate treatments and anti-psychotic medications.

(4) Supportive housing with high-level supports that does not evict people for behaviours that are due to their mental illness but keeps them housed and helps them improve.

(5) Privacy laws need to be reviewed so that families are included in the treatment plan of their loved ones.

Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Joanne. There are some bells ringing for a vote. Unfortunately you used up all your time, but it was an excellent presentation. I can tell you that out of all the recommendations you made—they're all good ones, obviously—number (5) is one we hear over and over again as a committee. I just wanted you to be aware of that. Thank you for coming today.

Ms. Joanne Purdon: Thank you very much.

THE NEW MENTALITY

The Chair (Mr. Kevin Daniel Flynn): Okay, we'll keep moving along, then. The next presenter today is The New Mentality: Cathy Dyer, Lorraine Cardoso-Hybner and Montana Goldrup. How are you doing?

Ms. Cathy Dyer: Good. I'm Cathy.

Ms. Montana Goldrup: Hi, I'm Montana.

The Chair (Mr. Kevin Daniel Flynn): And where is Lorraine?

Ms. Cathy Dyer: She couldn't make it.

The Chair (Mr. Kevin Daniel Flynn): Well, make yourselves at home there and relax. Like all other groups, you get 15 minutes. You can use that any way you see fit.

If there's any time left over at the end, we'll use that for questions. Thanks for coming.

Ms. Cathy Dyer: We're a little bit nervous, so we're going to leave some time for questions. The alarm is making us want to hurl a little bit. But we're trying to just relax.

The Chair (Mr. Kevin Daniel Flynn): We could probably close that door, unless it's going to make it really hot in here. You get used to the bells.

Ms. Cathy Dyer: My name is Cathy. I am the project coordinator for a project called The New Mentality, which is all about engaging young people to reduce the stigma of mental illness and to improve mental health services.

We're a program of Children's Mental Health Ontario and the Provincial Centre of Excellence for Child and Youth Mental Health at CHEO. We have New Mentality groups in communities like Kingston, Toronto, Smiths Falls and Burlington. These groups get to choose what they want to do to raise awareness about mental health. All the people in a group would be 13 to 24; 75% of them would have a mental health issue. Some of them don't. Some of them just really care about mental health and they are partnered with a local mental health centre to offer supervision.

The groups have been around and have been hugely successful. We had an evaluation of our project and found that the young people are being engaged for the first time in mental health. Typically, there are no volunteer opportunities, really, for young people to get involved in speaking out.

We also have a speaker's bureau, and that's what Montana is on. So we train speakers, and our speakers go out to provincial and national conferences. Last week, my colleague Nancy and a couple of young people were talking to police officers about the relationship between mental health and corrections. So we do a whole number of things. We gave Montana a call and said, "Hey, do you want to go and talk to the government about mental health services?" She said, "Yes," and I don't think she realized what that meant until she walked into the room.

The submission that you have here sort of describes some of the recommendations that other young people in The New Mentality have made about what they think should be improved around mental health services. These recommendations came from a conference that we did in 2008. Thirty-five young people did a really brief sort of powwow, like, "Let's brainstorm what the issues are and what we think the professionals should know," and then they presented them.

Just briefly, the recommendations they had that I wanted to share with you:

Youth and professionals need youth-friendly medication education. So often young people on meds don't know what they're taking. Even the professionals don't know how to explain it to them in ways that they understand.

Young people want to know more about their rights when taking medication. There are so few services that

when young people do get services, they're so excited that they don't think about the whole rights piece or that they have the right to ask about things. They would like more information about that.

The buildings and agencies serving young people aren't as youth friendly as they ought to be. People feel really intimidated to go for help. We think the agency should be more youth engaging. We have some ideas on how to do that.

Of course, we need more access to services. That means more beds, less restrictive criteria to get in for intake and assessment, those types of things.

But to really talk about what it is to be a young person with a mental health issue or mental illness, I was really hoping that you, Montana, would say some stuff about your experience.

1640

Ms. Montana Goldrup: Okay. I'm Montana. I'm 21 and I'm from Hamilton, which is like an hour from here.

I suffer from ADHD, I have a mild form of OCD, and my biggest one is that I have borderline personality disorder; it's a form of depression. From my understanding, from what I've learned and been able to grasp of borderline personality disorder, it's a form of depression and it's kind of different, because I feel different. If I do something wrong, I feel more guilty than other people, and my guilt takes me to the point where I feel like I don't deserve to be here. An example of that would be that when I get really down, it's even worse. Sometimes I just feel guilty. I'm a part-time nanny and one of my kids fell down and hurt himself really badly and needed to go to the hospital. I couldn't prevent that from happening. He's four; he's going to fall. But I just felt really bad, and I was like, "Oh my gosh, my kid fell down. I'm going to be fired." But it's not the case, because kids fall down all the time.

I was at my mom's house and she made me lunch. I used up all the bread, and I thought, "If I wasn't here, my mom wouldn't have run out of bread," and obviously, you can just go to the store and buy more. So I tend to feel a lot more guilty, and then my guilt takes me to the point where I feel like I don't deserve to be living any more.

It took me a really super-long time to get the help that I needed. I first started having issues with my mental health when I was nine; I was diagnosed with ADHD. Then, when I started middle school, around the seventh grade, I just started feeling really, really bad about myself, like I didn't deserve to live, and I didn't want to live. So I tried to kill myself. I think I was about 12 or 13.

My mom took me to the hospital because she found out what happened, and these doctors were telling my mom that there was absolutely nothing wrong with me, that it was just typical, normal stuff for teenagers to do. I have an older sister; she's four years older than me, and she never experienced this. It's like no one I knew felt the way I did, and maybe they did but I just didn't know it.

But I remember when I was younger, someone in my family attempted to kill themselves, and I kept saying to myself—I realized what it had done to my family and I was never going to do that, I was never going to put my family through that. But I did it, and I kept doing it over and over again. I was 15 and I almost died because I tried to kill myself.

My mom couldn't take it any more. It came to the point where she couldn't work; she lost her job because she had to be constantly by my side. Finally, she yelled at these doctors, "Listen, there's something wrong with my daughter and you need to help her." I was placed in a group home and then for the year that I was living in that group home, I did get the help that I needed. But my psychiatrist got sick and went on medical leave, and that was it. That was the end for me. No one helped me again. To this point, since I was 16, I have never seen a psychiatrist. I still suffer from mental illness, and it has come to the point where I've just had to do it myself, because no one out there is willing to help me.

I'm 21. Before my 18th birthday, I had attempted suicide over 30 times, and I have serious organ issues because of that, because no one would help me. I know so many people—and I'm not going to lie; I've done this myself—who go to the hospital. I've waited 18 hours at a hospital. I go to the hospital one morning, and I'm still in that emergency room at 2 o'clock the next morning, just waiting for someone to help me.

Then they come, and they spend 15 minutes with you. If you don't have a plan, if you don't tell them, "I'm going to leave here and go kill myself," or even if you say that, if they ask, "What's your plan?" and you don't have a plan, they're not going to help. If you don't have a plan, then you're not going to do it. That's not true. If you are in the mindset where you just want to die, you're going to do it, automatically. I've drunk nail polish remover, I've drunk bleach, crazy things, because that's what's accessible to me.

There are times when kids just do something to hurt themselves, just because they know that it's the only way they're going to get the help they need. That's so unacceptable. Kids are dying because nobody will do something unless they've done something, and that's not good.

I don't care how old you are. If you go to the hospital and tell these doctors, "I want to kill myself, I'm going to kill myself," if you've cut yourself, if you haven't eaten in three days because that's the only thing you know, then they need to help you. I go to the hospital and they treat me like I'm garbage.

I live on my own and I'm with Good Shepherd services of Hamilton and I have a worker. She took me to the hospital, and the nurse was so rude to me, she wouldn't let my worker Catherine come into the hospital with me. I need music to calm myself down, and she wouldn't give it to me. She made me wait in that room for three hours, then came and spent five minutes with me. No doctor saw me—no doctor at all—and then she told me to go home. I was lucky I had Catherine, because

she helped me through it, but the last time I tried to commit suicide was February—not the February that just passed, but the February before that. I'd been released from the hospital a week before that happened. The week before that, I was in the hospital every day before they finally decided, "Look, this girl needs help," and they admitted me. I did not want to leave the hospital. They told me that I had to leave, that I was better because I didn't feel like I wanted to kill myself anymore. Just because I didn't feel like I wanted to kill myself didn't mean that I should have left the hospital. I told the doctor, "If I leave here, I'm going to kill myself."

I tried to kill myself at my grandmother's house. My grandma has always been my support, and I made a promise to her that I would never, ever do something in her care. I was so down that I left the hospital, and instead of returning to my group home I went to my grandma's house, and that night I tried to kill myself. If you're willing to break a promise like that to the most important person in your life, then you're obviously needing the help. It just shouldn't come to that.

The Chair (Mr. Kevin Daniel Flynn): Thanks, Montana, for coming. Thanks for telling your story. You still have time left. Can we ask you questions?

Ms. Montana Goldrup: Sure.

The Chair (Mr. Kevin Daniel Flynn): Or do you need a minute to calm down?

Ms. Montana Goldrup: I'm okay.

The Chair (Mr. Kevin Daniel Flynn): It took a lot of guts to tell that story.

Christine, Sylvia, do you have any questions?

Ms. Sylvia Jones: Thank you, Montana. Your story is important for us to hear. Can I ask you how long you've been involved in the New Mentality project?

Ms. Montana Goldrup: When did The New Mentality start?

Ms. Cathy Dyer: Two and a half years.

Ms. Montana Goldrup: Two and a half years, since day one.

Ms. Sylvia Jones: And you've been on their speakers bureau?

Ms. Montana Goldrup: The speakers bureau just started this summer, but we had a New Mentality project in Hamilton and it failed completely. We lost our adult ally and then we had to wait months to get a new one. We were working with Good Shepherd and then we had the mental health nurse who worked with all the street youth, and then she left to get a new job. So when they hired the new one it was like, four months, and then she had to train for that job and be our adult ally as well. It just kind of didn't work, but I still stayed involved in its other stuff and I work with other organizations. I work with PCMH and I work with a consumer advocacy network in Ottawa.

Ms. Sylvia Jones: Well, I'm going to take a wild guess that you are a very effective speaker for The New Mentality.

Ms. Montana Goldrup: Yes.

Ms. Sylvia Jones: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Sylvia. France?

M^{me} France Gélinas: When you reach out for help, do you have a primary caregiver like a nurse practitioner or a physician?

Ms. Montana Goldrup: This is my mom's issue too: My family doctor is a learning doctor's office, so whenever I go to the doctor's, I see a different doctor every time. We're trying to change that, but even if I just go to the doctor's and tell them that I'm feeling down, they automatically send me to the hospital and they try to give me medication. I don't think medication is good for me because even as a general thing, unless I'm seriously dying, I don't like to take medication at all. If you've tried to overdose 30 times, then that's not something you're going to want to do. I'm still prescribed medication, but I can't take it. Just the whole process of taking medication is not something that I can do.

The other thing is that I'm on a waiting list and I've been on a waiting list for two years. I'm admitted to the hospital, I go on this waiting list, then when you're readmitted to the hospital, you're taken off the waiting list because you're in the hospital, so you're getting the care that you need. So you leave the hospital and you're taken off the waiting list; two months later you're readmitted to the hospital, you're taken off your place on the waiting list and put back at the bottom.

The waiting list for care can be up to two years and that needs to change. My parents had to put me in a group home; it was an either-my-kid-doesn't-live-with-me-or-my-kid-doesn't-live-kind-of-kind of thing. It took a really long time for that to happen as well.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Any quick questions over there?

Mrs. Liz Sandals: Yes. Thank you so much for coming, Montana, and sharing your story with us. When you say you're on a waiting list for care, what sort of care or treatment—

Ms. Montana Goldrup: Just to see a psychiatrist.

Mrs. Liz Sandals: When's the last time you actually saw a psychiatrist?

Ms. Montana Goldrup: Probably when I was 16.

Mrs. Liz Sandals: So you haven't really had any—

Ms. Montana Goldrup: It's just when I go to the hospital and it's, like, nothing. They sit with you for five minutes and treat you like you're a piece of trash.

Mrs. Liz Sandals: But in terms of sort of an ongoing relationship with a particular psychiatrist, you haven't had one for a very long time.

Ms. Montana Goldrup: No.

Mrs. Liz Sandals: How did you get involved with the New Mentality program?

Ms. Montana Goldrup: I was living in a group home. On the girls' floor, there was a bulletin board and it had all this information about The New Mentality, and I thought it was something that I really wanted to do.

It's really, really helped me. Even Cathy and Nancy were saying today at lunch that I've grown up a whole lot since I first began and this has helped me.

My life has been pretty much hell since the day I was born—so if I have to do this, at least I can take something out of it. I have a three-year-old niece, and I don't want anyone, especially her, to ever have to go through what I've been through. So if sitting here today can make that happen, then that's definitely something I want to do.

Mrs. Liz Sandals: Thank you so much for coming. We really appreciate your courage.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much.

Our next two speakers aren't here, and we're faced with a 13-minute break. Is any one of our speakers here who is going to speak? Is there anybody in the audience who is scheduled to speak? If not, we're going to adjourn.

The Clerk of the Committee (Ms. Susan Sourial): Recess.

The Chair (Mr. Kevin Daniel Flynn): Recess. I tried. I thought I could sneak one in there.

We're recessed until after the vote, anyway.

The committee recessed from 1648 to 1708.

HDH/KGH MENTAL HEALTH PROGRAM

The Chair (Mr. Kevin Daniel Flynn): Okay, if we can call to order again. Our guests have arrived, and we've had a little bit of a change in the agenda.

Our first presenters are Peter Kennedy and Roumen Milev, if you'd like to come forward. Thanks to Dr. Brown for allowing the change in the agenda.

Thank you for coming. Like all other presenters, you have 15 minutes; you can use that any way you see fit. If there's any time at the end for any questions and answers, we'll try to split that evenly amongst the groups here. The floor is all yours.

Dr. Roumen Milev: Thank you for inviting us and listening to us. I think this is our first presentation to any such committee, so we are a bit nervous. I'm Roumen Milev, and I'm a psychiatrist who works in Kingston. I'm the head of the Queen's University department of psychiatry and also chief of psychiatry for the affiliated hospitals—Hotel Dieu Hospital, Kingston General Hospital, Providence Care and also Quinte in Belleville—and also for some of the community services in Kingston, Frontenac Community Mental Health Services and some other smaller community services.

I've been in Kingston for about eight years now, and I have learned quite a lot about the organization of mental health in Ontario from that experience. In the past, I have worked in other jurisdictions in Canada. I've worked in the UK and Russia, and I originally come from Bulgaria, where I also worked as a psychiatrist. I've seen a variety of different ways of organizing, from the point of view of administration of mental health, from one extreme communist dictatorship to the other and everything in between.

I think that what we came here to do is really to ask you to consider several important things in our mind

which we would like to see happen in the future of mental health in Ontario.

Mental health is in a unique situation amongst the medical specialties because, on one side, it is regarded as a medical specialty. Now, with more and more that we know about mental health, we find more and more that mental health is based on some medical changes of the brain. But we also know quite well that the environment is very important for mental health for both developing mental health problems and also healing, and it has to be taken into consideration.

Mental health is also unique because of the stigma attached to mental illness. For example, I don't know how many of you can come here to work today and say to your colleague on the left or the right, "My suicidal thinking actually got worse last night, totally worse. I didn't know what to do." It's not accepted. You can say, "Yes. I had a migraine. I had diarrhea," even, or something, but you cannot say that your voices started talking to you again.

So, in a way, it has a lot of stigma still. It has a stigma also within the medical profession. In general medical offices we see that quite a lot, when psychiatry is treated as a poor child of all the other specialties, specifically surgery, medicine, and that interferes significantly with our ability to attract new students to come and see us.

What we really want to see is planning for the services being population-based. We see this as talking about that, but when it comes to deeds, when it comes to things done, nobody uses population-based planning anymore. There are examples galore. For example, last year, one of the associated hospitals decided to cut eight in-patient beds due to fiscal constraints without any consideration of what the population-based needs are and the wider impact that might have. We saw exactly the same situation in another hospital this year. It's a constant issue which arises and it's not really based on sound grounds.

The other important thing we need to talk about is the need for a system approach. Mental health, again, is unique in that way. It cannot function without looking at the whole system, without looking at all the other players who provide services for the same population. I can make an analogy. In surgery, whether your surgical department is integrated with the next hospital doesn't matter that much. You can get your operation here or there; that wouldn't matter. In mental health that matters a lot, because unless the hospital talks to the other hospital, unless the hospital talks to the community mental health services, unless the hospital is aware of what is done elsewhere, and the same for the community, the patient will not receive the best service because the patient travels from one place to another. I think the need for a system approach is very important.

Local health integration networks seem to be the natural place where such an integration can occur, but we don't see that happening in the LHINs. We know now the LHINs are talking about a surgical program being integrated across the LHIN, or emergency room or wait list

strategies, but mental health is never on the agenda. This is why I think that this is a very important issue that we need to raise.

From my point of view, as the chair of a department of psychiatry, I work with each of these local hospitals and all the community providers and I can see how they don't talk to each other. It happens that I attend many of those meetings. I run like crazy from here to there to there all the time; I get a stack of parking tickets that big. But the thing is that those people don't talk. They don't know about the other one. We have attempted some of those local integration things, but unless this is really taken seriously by the LHIN and requested, I don't think this will happen and go anywhere more than just local initiatives here or there.

With that, I'll stop here and let Peter talk a little bit, and then we'll be happy to answer any questions.

Mr. Peter Kennedy: My name is Peter Kennedy. I'm the program operational director for the mental health program at Hotel Dieu Hospital as well as Kingston General Hospital.

What I'd like to do is refer to the handout that was provided, and really that drills down to the specific areas that we see are priorities for creating that integrated system of care that is so desperately needed. It's probably been talked about now for 20 to 30 years without it being realized, and we've lived through a series of reports, operational frameworks, and none have been executed, I believe, successfully.

In terms of the existing system organization, building on what Dr. Milev just said, the need for a senior manager in each LHIN having responsibility for mental health services across a LHIN for primary, secondary and tertiary-level care, in-patient and outpatient services—we see that as a critical way of creating that systemic quarterback who can really have that overarching view of the services that are required.

1720

We also are left with benchmarks that are outdated. We often have to look at recommendations for staffing models and services that are 10 or more years old, which really does not reflect the current state of the acute in-patient services or specialized services within our communities.

Further, we would look to help with ensuring that we create a systemic way of gauging our human resource needs, whether they be psychiatrists or other mental health professionals. Again, we're left with some data that's available from out of country or older data that is 10-plus years old. We really need to be able to say, for the needs of our communities these are the staffing requirements to be successful in delivering the type of care expected by residents.

Further, I'm challenged every day by what the medical-surgical areas are challenged with, and that is ALC patients. Those are folks who have completed their acute care needs and need to be transitioned to the community. But we find, again, as a result of stigma and behavioural issues and challenges, that often the long-

term-care facilities and complex-care facilities are reluctant to take clients who have completed their acute care. That leaves us with the difficulty of having people who may be housed in our emergency department for a weekend or longer, not receiving the right care in the right setting. So we would suggest that if there are opportunities or ways of strengthening the resourcing of the long-term-care facilities in terms of their ability to care for our clients with coexisting psychiatric disorders, that would be very helpful.

Further, as I have said, we have experience with a series of strategic planning documents, operational frameworks and so forth in looking at mental health services in Ontario; however, we continue to have significant gaps in the continuum of services which would allow us to step down people to less resource-intensive care levels if those services existed. They simply don't, and so we have gaps between acute in-patient care and then outpatient services without any services that can work with the individual in the intervening period.

I would also suggest that there is not a balance in the system in terms of care that's required. I recently had the opportunity to work with the Limestone school board around children who are at risk. Between the acute hospital setting and the school board and whatever services they can provide within their system, there really doesn't seem to be that mid-level service. Really, it was quite fascinating to look at how an individual who may be at risk has to migrate through these various levels of care before we can engage them appropriately. Based on the experiences with the Limestone school board and other providers who provide services to children and adolescents, it's clear that there is a real resource deficiency for the children in our communities.

One of the things that I would also like to point out is around the benefit that we've enjoyed as a result of Dr. Milev having the headship and also the psychiatric leadership responsibility for multiple agencies, both hospital- and community-based. That has allowed us to work with other agencies much more effectively in terms of coordinating access, improving access, working through the barriers of different organizational cultures and allowing us to ensure that we can provide timely and appropriate care to individuals. That's not through additional resources being infused; it's simply by having the architecture of an overarching psychiatric leadership position, which allows us to engage other organizations much more effectively.

I would also like to briefly speak to the need for looking at opportunities to work with those persons with chronic, recurring psychiatric illness in the same way that we have looked at providing care to other individuals, whether it be those people with asthma or diabetes. Certainly the government has invested huge amounts of resources in working with those persons with diabetic illness. Likewise, I think there are real opportunities to look at disease management programs for disorders such as depression, which has a much higher illness burden, based on the WHO classifications, than diabetes mellitus.

So I think there are some real opportunities to provide care in a different way that is proven and it's an opportunity to do so without infusing large amounts of resources.

I think that at this point I'll conclude my comments.

The Chair (Mr. Kevin Daniel Flynn): That's pretty good timing because you just used up the 15 minutes.

Mr. Peter Kennedy: Did I? I'm sorry.

The Chair (Mr. Kevin Daniel Flynn): That was excellent. Unfortunately, you didn't leave any time for questions, but I'm sure the committee understood your presentation. It was very thorough. Thank you for coming all the way from Kingston to make it, and I hope you make your train on your way back. If you do, you'll have Dr. Brown to thank.

Dr. Roumen Milev: Thank you.

ALAN BROWN

The Chair (Mr. Kevin Daniel Flynn): Alan, if you'd like to come forward; make yourself comfortable. I think you were in the room when I outlined the rules. They're pretty simple. You get 15 minutes; use them any way you see fit. If you could leave some time at the end for any questions, that would be great.

Dr. Alan Brown: Thank you very much, Kevin, and members of the committee, for allowing me to speak to you today. I'm here for a couple of reasons. One is to provide some back-up support to a program at the Woodview Manor, which exists in Hamilton, for the residential treatment and support of autism spectrum disorders; and number two, there are particular gaps in the service for autism spectrum that I think need to be addressed along with that.

I'm a child and adolescent psychiatrist. I am the medical director of the child and adolescent in-patient service for Halton Healthcare Services. Halton Healthcare Services, again, is a three-hospital group—Oakville, Georgetown and Milton hospitals. I'm also chief of the department of psychiatry for Halton Healthcare Services.

What is autism? It's a complex neurodevelopmental disorder. It's a brain disorder that occurs throughout the course of development and affects the function of the brain. It causes two particularly important concerns. One is impaired communication and social interaction; and two, repetitive behaviours and restricted interests that become problematic for reasons I'll explain later.

How prevalent is it? It affects 1% of the population. That's 70,000 people here in Ontario. It's just as prevalent as schizophrenia. There are subtypes. I don't want to bore you with the subtypes other than to note that there are autism spectrum disorders with intellectual disability, i.e. IQs under 70, and autism spectrum disorders without intellectual disability, which is what we call higher functioning, with IQs of 70 or above, and they include things like pervasive developmental disorders not otherwise specified and Asperger's syndrome.

Fifty per cent of autism spectrum disorders have normal intelligence. This is important to understand because

while they have normal intelligence, they are just as disabled, given the continuum of concerns, as those who have IQs below 70. There are particular challenges these individuals with ASD must face: communication difficulties due to difficulty understanding verbal communications, verbalizing thoughts and feelings, and processing verbal information. This problem leads to frustration and, in terms of their interaction with others, socially disruptive and, at times, dangerous behaviour.

1730

Socialization difficulties: Many of these people want to participate in social activities and may have difficulty engaging and not have the social skills to maintain social fluency, but their difficulties lead to particular problems understanding social rules, things that we take for granted—for example, not to pick your nose in public; that may seem like a very obvious thing. There are certain things that people do and they're just not aware of the social impact of them.

Anxiety: Most of these individuals suffer from a pervasive and very significant degree of anxiety that's overwhelming and causes catastrophic reactions on their part. They're just feeling overwhelmed, can't manage the environment and what's going on around them, and then develop markedly disruptive behaviour as a result of this, sometimes self-injurious and sometimes other-injurious.

They have difficulty with executive functioning. We have a part of our brain up here, right at the front—one of my autistic patients refers to this as the "oval office"—the dorsolateral prefrontal cortex. When I ask him why he's had a particular problem, he says, "The President wasn't in." I've used that description with many of my patients when we talk about executive functioning, and it certainly captures it.

Difficulty with change: One small change in an environment for these patients—you know, you move a book or you move your vase—they come into the office and they start to become markedly agitated and you don't know what's happened. They just can't tolerate changes as small as that.

Perseveration: They fixate on topics. They feel the need to complete tasks. For example, a student in school who is doing his math homework in a math class, when the bell rings, won't get up and want to leave. The teacher will say, "Come on, you've got to get up and get on. People from the other classes are coming in," and it can lead to very simple disruptive episodes that can in fact become violent at times.

This pattern of perseveration also interferes in their social skills because they start to talk about an area they like very well. They keep talking and talking and don't see the eyes glassing over on the people around them, so they drive people away from them even though they want to be socially engaged.

Emotional responses and reactivity: Many withdraw and isolate themselves. They may appear anti-social, like they don't want to be part of things, when in fact they do. They just don't have the skills to engage. They may become clinically depressed and may suffer from rapid

and significant mood swings, or they can even develop psychotic symptomatology, like paranoid delusional thinking or hallucinations. In a recent study, 43% of ASD adults endure significant symptoms of depression on standardized psychiatric questionnaires.

So the issues arising are that they are extremely isolated and alienated without significant supports in trying to engage in our communities. They are terribly misunderstood. They don't just misunderstand others, they themselves are obviously significantly misunderstood, and they fail socially. They're unable to cope with our traditional educational system. They fail academically because they don't fit socially, they persevere and they get stuck, and they can't process information the same way. They're marginalized.

They develop mental health disorders. Psychiatric comorbidity, as I said, is very significant with this population. One of the interesting things is that this population falls within the developmental services sector, but the mental health interface is huge, and I think we have to look at addressing the interface that these individuals have to deal with, rather than getting segmented out by systems in the way our social support systems are in fact structured.

They can become, as I say, behaviourally disruptive, explosive and potentially dangerous. I run an in-patient service. The most common reason they're in my unit is they've assaulted people, they're threatening or they're acting in such a way as to place themselves at marked risk.

You've probably heard of the young woman who strangled her autistic child this past week in the Mississauga area. Last summer, an autistic late adolescent either fell or was pushed into the lake and drowned at a dance when he was socially inappropriate.

These particular issues they deal with break apart the families in which they live. It leads to 98% of ASD families reporting that they've suffered from significant ongoing crises in their lives in a recent survey by Autism Ontario. They often end up hospitalized on mental health units such as mine that aren't equipped to manage the complex levels of care that are in fact needed for these individuals. Once they're on our unit, because there's not a full continuum of care and not step-down programs like residential programs such as the Woodview Manor offer, they remain on our units, an inappropriate setting. I've had one young man in the last year, it was a 12-month period—my unit is designed as an eight-day length-of-stay unit; he was on that unit for nine months. That per diem cost to the health care sector is huge compared to what a comparative residential program in the community would in fact be. When they're on our units they still don't fit in and staff have a hard time managing because our staff are not trained to deal with autism spectrum disorder. They're learning to be trained over time as we see more and more of these individuals come to our attention.

The needs: Obviously the intensive behavioural intervention services for the lower-functioning IQ, language

and social skills component of the ASD spectrum have been extremely helpful. They're occurring in the younger age groups, and that's tremendously helpful. Social skills training, though, is something these individuals need throughout the age continuum, but especially during developmental transitions: the time they enter school as young children, the time that they enter adolescence because of the change in their peer structure, and the time that they leave adolescence and go into adulthood. These are critical times for social skills training.

Respite services: They need respite services from families because the pressure and stresses on families are profound. These respite services need to be structured in such a way that they're with people of a similar functional level, because of the continuum of ability. To place a higher-functioning autistic spectrum with a lower-functioning autistic spectrum just doesn't work. We need to understand that breakdown, and we need to understand when we talk about high-functioning autism, these are not people who don't need help. These people need help just as much. This is the segment of the population that I think we need to address at this point in time more fully.

Residential treatment services, especially from mid-adolescence to adulthood: We need residential treatment services for these individuals. They are often available for the lower-functioning end of the ASD spectrum and continuum, but they are significantly lacking for the higher functioning, i.e., average or above-average IQ and verbal skills. Brief in-patient mental health services are often required. They need to be brought into hospital for reassessment, for medication management and to contain risks to self or others, but to leave them on a unit for nine months because we don't have a suitable placement to transfer them to is clearly inappropriate.

Access to mental health social workers, psychologists and psychiatrists—in other words, people in the mental health field with training in the recognition, assessment and treatment of ASD: We need to enhance our training programs for all of our mental health workers in dealing with the autism spectrum disorder, because while they may be segmented to the developmental services sector, this really leaves them out in the cold. We need help in being able to offer the kinds of services in mental health to manage these people and transition them back to the communities. We need seamless transitions along a more fully developed continuum of care, from outpatient to day treatment to residential services and in-patient treatment, in-patient treatment being a last resort but many times being useful.

But again, if you clog up one component of your treatment continuum and you can't move people out, then other people can't access it: 20% to 30% of my in-patient days in my unit are filled by autism spectrum patients, again, typically because we have nowhere to place them to. The families can't manage them and so we're leaving them sitting at our in-patient services. It becomes inhumane to them over time. An eight-day program becomes repetitive for anybody.

Occasional rehabilitation services to enable ASD individuals to go find and maintain whatever meaningful employment is possible: Certainly, moving towards the adult range, many of these people can in fact be employed, but the kinds of supports we need in terms of employer supports and job coaching to help them function are very significant. Many of these people have particular skills and talents that are quite amazing, and I think not to utilize them and help them fit into our culture does both them and us a tremendous disservice.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Alan. We appreciate the presentation. You've left about two minutes for some questions. France, you're first.

M^{me} France Gélinas: Wow. I'm very grateful that you came in and talked to us today. You are the first psychiatrist who concentrates on autism who has come, so that makes it that much more interesting. Are they common?

1740

Dr. Alan Brown: One percent of the population, so—or the psychiatrists?

M^{me} France Gélinas: No, I'm talking about the caregivers.

Dr. Alan Brown: Actually, less than 1% of the population.

The Chair (Mr. Kevin Daniel Flynn): That's a lot of psychiatrists.

Dr. Alan Brown: I think they're having to learn by the seat of their pants. I deal with my adult colleagues; many of them are very uncomfortable treating the disorder. They just don't know enough about it. It hasn't been included in their training. They need backup and support. Other child and adolescent psychiatrists I see are also uncomfortable. I know several who are but it's a skill and an awareness that's tremendously lacking.

The Chair (Mr. Kevin Daniel Flynn): Time for one brief question. Liz?

Mrs. Liz Sandals: Thank you so much for coming. I take it that you've also got a bit broader issues than autism that you're interested in as well. What I find really interesting is that you're talking about respite services similar functional level and residential similar functional level. I've heard from people maybe who were suffering from depression and participating in some sort of a community peer support group that it wasn't very effective because it wasn't of a similar functional level in terms of education. Is this something that is becoming more of an issue, that as you set up supports, if you don't get the right mix of people then the support isn't all that effective?

Dr. Alan Brown: That's exactly right; one size doesn't fit all. As we first of all try to support the developmental health services, that's a wonderful thing, but I think the more aware we become in terms of our knowledge, we begin to understand that "different strokes for different folks" is really still important. Subspecialization, as in other areas of medicine, is also true in mental health.

The Chair (Mr. Kevin Daniel Flynn): We probably can take the clock down to three minutes if Christine or Sylvia has a question of the doctor. Christine?

Mrs. Christine Elliott: Thank you very much, Dr. Brown, for coming. As some of my colleagues have said, you are the first specialist in this area who's been able to come to the committee, so we're very grateful because we have been struggling with how to deal with autism as part of this committee. We know that people with autism have the needs that you've described. You've described it as a neurodevelopmental disorder. So the mental health piece: Is it that there are some pieces of that neurodevelopmental disorder that express themselves as mental health issues, or is it because of the lack of treatment that the mental health issues are emerging?

Dr. Alan Brown: Both. The parts of the brain that are involved in terms of developing or causing the development of an autism spectrum disorder also are involved in the promulgation of anxiety, and there's a greater susceptibility to significant mood issues in depression. There's an overlap here that I think is important to understand. It's very important to understand that so we know that we can't just deal with it from one sector, developmental services. It's got to be a mental health and developmental services sector interface. Both are, in fact, critically important.

Mrs. Christine Elliott: Thank you for clarifying that.

The Chair (Mr. Kevin Daniel Flynn): For those members of the audience who think everybody's just going to take off and leave them, we have to go upstairs and vote in three minutes. That should take maybe five minutes. So you'll probably see us all again in about 10 minutes. Thank you. We're recessed.

The committee recessed from 1740 to 1749.

WOODVIEW MANOR PARENTS' COUNCIL

The Chair (Mr. Kevin Daniel Flynn): Welcome, Michael. Thank you for coming. If you'd introduce your colleagues. You've heard the rules: 15 minutes and leave some time for questions. It's all yours.

Mr. Michael Noga: Okay. After the introductions, the 15 minutes start, okay?

The Chair (Mr. Kevin Daniel Flynn): Okay.

Mr. Michael Noga: Cindy l'Anson, director at Woodview Children's Centre, and Rick Ludkin, director of autism services development. My name is Michael Noga. I am representing the Woodview Manor Parents' Council. My son is autistic and is at Woodview.

Without further ado: the problem.

The prevalence of autism spectrum disorder, ASD, has increased from four in 10,000 in the mid-1980s to 61 in 10,000. This means that today, approximately 75,000 Ontarians have ASD.

Three quarters of this increase occurred in people deemed to be high functioning. The term is misleading. It simply means they have an IQ above 70. They are still affected by the triad of symptoms that characterizes ASD; namely, qualitative impairments in social inter-

actions, qualitative impairments in verbal and nonverbal communications, and restricted and repetitive interests or behaviours. In short, they have difficulty leading normal lives. However, with the appropriate supports and environment, they can live fulfilling lives.

High-functioning ASD adults seem to be more prone than those with ASD and an intellectual disability to have comorbid psychiatric conditions. These are mainly mood and anxiety disorders. It is estimated that 40% of the adolescents and adults with ASD have comorbid psychiatric problems. They have difficulty making friends with adults their age and, when isolated and lonely, the mood and anxiety issues are exacerbated.

Adults with ASD simply don't fit into everyday society. Without employment, isolated and with nothing to do, they are challenging or impossible for parents to deal with. Frustrated, they often lash out at those around them.

Typically, these individuals do not receive services until they are in crisis and have been hospitalized for treatment of their mental health issues. Hospitals find that there are no resources to discharge them to. They become bed blockers. There is no cure for ASD or the comorbid mental health issues.

The supports for adults with ASD and their families are virtually non-existent in Ontario. These adults need an environment apart from their parents where they can gain confidence by learning to look after their basic daily needs, learning social and communication skills so they can cope more effectively and have a community where they fit in and a social support network. Without this support, they often end up back in hospital or worse each time there is a crisis in their lives. Rarely, some individuals end up in jail and prison, most often for offences that are related to obsessional tendencies or impaired social understanding—both typical autism traits rather than criminal intent.

The "high-functioning" ASD group does not receive services through the Ministry of Community and Social Services because their IQ is above 70, and they are not eligible for services through the Ministry of Health and Long-Term Care because they have a developmental disability—ASD. By default, the servicing of this group falls onto the Ministry of Health to provide the ongoing psychiatric support and crisis intervention with very costly and scarce resources.

The alternative is Woodview Manor's autism program centred in Hamilton. It is proactive in that it provides a wide range of services and supports that begin, ideally, when the person is young and allows them to move through a graduated system, learning age-appropriate skills with their peer group, and leads ultimately into a supported independent residential program, when needed. The programs are delivered by people with specific knowledge of and training in autism. Woodview's services are not a reaction to people or families of ASD individuals reaching a crisis in a service vacuum. Rather, they are an education and support program to keep them from getting to a crisis situation. Last year, none of the

clients serviced by Woodview required outside crisis management or hospitalization for mental health issues.

Woodview's program is cost-effective. It currently supports more than 65 children and youth and over 65 adults with ASD, and a further 18 adults with schizophrenia, on a budget of less than \$700,000, or \$5,400 per client per year. The program builds life skills from an early age and helps youth to develop a social network through a seamless program, resulting in many adults requiring reduced levels of support as they age. Further, those supports are targeted to meet very specific needs. Research shows that adults with a satisfying quality of life rarely need the significantly more expensive hospital services when their lives fall apart.

Woodview Manor's autism program was started in 1988 and has been called on to provide services to the surrounding regions. For the past 20 years, on a limited basis and as space and resources have permitted, they have admitted youth from Halton—ironically one of the wealthiest areas in Ontario—Brant and Niagara. Each area has identified the need for a similar array of services. In the present climate of monetary restraint, Woodview has been instructed not to admit youth or adults from surrounding areas. Yet the demand for this program from these regions is ever increasing. The increasing demand for services can only be met by increasing the special training through funding that reflects the savings that this program provides the health care system.

Woodview has been approached by other jurisdictions in Ontario and across Canada to set up this unique autism program in their areas. They all face the same challenge, that of managing the growing population of ASD children, teens and adults with co-morbid mental health issues in a more cost-effective fashion.

Kevin Flynn, MPP, has toured the Hamilton facilities and met staff and some of the clients.

There is no cure for autism and the comorbid mental health issues. This population is growing in numbers and will need mental health services on an ongoing basis throughout their lives. The less costly approach for the Ministry of Health is to provide this intervention on an ongoing proactive basis by people with specific knowledge of and training in autism rather than through the more expensive psychiatrists and hospital psychiatric wards.

1800

The Woodview Manor autism program is an excellent model of service delivery for the ASD group. It is cost-effective, proactive and readily duplicated. It is an ideal model for interministerial collaboration in the funding of service elements—collaboration that could include MCYS, MCSS, MOE, MOH and MOHLTC. Some costs are already being borne by the respective ministries. Collaboration in this new direction could lower the overall cost of providing supports to this population now and in the future.

The Standing Senate Committee on Social Affairs, Science and Technology issued a final report in March

2007 on the inquiry on the funding for the treatment of autism, entitled *Pay Now or Pay Later: Autism Families in Crisis*. One of the recommendations was that the federal government convene a federal-provincial-territorial ministerial conference which, among other objectives, would define the feasibility of introducing measures such as supports for caregivers, including respite, family training and assistance, assisted living support, as well as career and vocational training. Woodview Manor's autism program already meets these objectives.

Ministry of Health dollars will be spent for ASD individuals. Would it not be more efficient to spend these dollars providing the ongoing supports with less costly resources, so that crisis intervention can be avoided, resulting in a better outcome for all?

The Chair (Mr. Kevin Daniel Flynn): Thank you, Michael. You've left a lot of time for questions, probably over two minutes for each of the parties. Anybody on the government side with a question? Liz?

Mrs. Liz Sandals: Yes. I'm not trying to be obtuse, but is Woodview Manor a residential program where people live permanently or is it a community support program where people come frequently?

Mr. Michael Noga: Rick would be the best to speak to it.

The Chair (Mr. Kevin Daniel Flynn): Could you identify yourself, Rick, for Hansard?

Mr. Rick Ludkin: Rick Ludkin. I'm the director of autism services development for Woodview. In fact, it's both. There are some individuals who require ongoing support and other individuals are living in the community with limited amounts of support, and we offer a full spectrum.

Mrs. Liz Sandals: I'm interested again in the fact that you're identifying high-functioning people with ASD as being more likely to have the comorbid; right? Often with mental health disorders we find that it's during adolescence that those start to show up. With the ASD population, is that similar, that it's during adolescence, or is it when they age out of school and become young adults and no longer have the school supports?

Mr. Rick Ludkin: No, it's starting to show up in school, especially when they make the transition into high school.

Mrs. Liz Sandals: Okay.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Rick. Sylvia, Christine?

Ms. Sylvia Jones: You mention that you have been instructed not to admit youths and adults from surrounding areas. Was that from the LHIN? Where did that instruction—

Mr. Rick Ludkin: From the Ministry of Community and Social Services, our region.

Ms. Sylvia Jones: I guess you didn't get to question why.

Mr. Rick Ludkin: Yes, we have questioned why and they're saying the funding has come to the Hamilton region and we're supposed to limit it to Hamilton, despite

the fact that historically we've always provided services to Niagara, Brant and Halton.

Ms. Sylvia Jones: Or that it's not available in Niagara, Brant and Halton.

Mr. Rick Ludkin: We've stressed that for the last 20 years, but it's gone nowhere.

Ms. Sylvia Jones: Okay. Thank you.

Mr. Michael Noga: I live in Oakville and my son is in the residence program. So I'm the individual who is saying that out of the richest city in Ontario, we've had to go to Hamilton to get the services.

Ms. Sylvia Jones: And I'm assuming that's because it was not available to you in Oakville and your son has been grandfathered because he was already in the program.

Mr. Michael Noga: Correct.

Mr. Rick Ludkin: Our program is the only program that provides these services for high-functioning people in the province, and it's an artifact of the way the funding was in the late 1980s.

Ms. Sylvia Jones: And you've been specifically told not to accept—

Mr. Rick Ludkin: Yes, within the last four months.

Ms. Sylvia Jones: Thank you.

The Chair (Mr. Kevin Daniel Flynn): France?

M^{me} France Gélinas: Where does your funding come from and what is it for?

Mr. Rick Ludkin: Three quarters of our funding comes from the Ministry of Community and Social Services, and that's to provide a range of residential supports; 25% of it comes from the Ministry of Children and Youth Services, and that's what provides some of our respite and children's and teen group programs that give us the opportunity to provide a range of seamless service on a proactive basis.

I should say as well, though, that our whole vocational program is funded by grants. The Ontario Trillium Foundation is the largest factor in supporting that.

M^{me} France Gélinas: What's your total budget?

Mr. Rick Ludkin: It's around \$640,000 at the moment for the whole range of children, teens and adults.

M^{me} France Gélinas: Okay.

The Chair (Mr. Kevin Daniel Flynn): Thank you for coming. And as you noted, and for the committee members, I've toured—it's a group of town homes that you couldn't pick out from any other town homes in the community. It looks like one of those things—well, obviously, I'd like to see one in my community. I think any one of us around this table would want to see one. It seems to be one of those examples where you can save money and do the right thing at the same time, and those opportunities don't arise often. That's why I actually encouraged the group to come before the committee, because there's really something special happening there.

Mr. Michael Noga: Thank you very much.

The Chair (Mr. Kevin Daniel Flynn): Thanks for coming today.

SENIORS HEALTH RESEARCH TRANSFER NETWORK

The Chair (Mr. Kevin Daniel Flynn): Our last presenter of the day—and thank you for changing and allowing the folks from Woodview to go first—is Robin Hurst, from the Seniors Health Research Transfer Network and—no? Robin didn't come?

Dr. Lisa Van Bussel: I'll go ahead and start and then maybe I'll clarify the introductions. Robin's not here.

The Chair (Mr. Kevin Daniel Flynn): Okay, very good.

Dr. Lisa Van Bussel: I think there has been a handout passed to the committee. Is that correct?

The Chair (Mr. Kevin Daniel Flynn): Should be, yes.

Dr. Lisa Van Bussel: I'm Dr. Lisa Van Bussel, a geriatric psychiatrist with St. Joseph's Health Care, London, which includes Parkwood Hospital and Regional Mental Health Care, London. And I have Julia Baxter, who is the manager for the geriatric mental health outreach programs through Hamilton.

Interjection.

Dr. Lisa Van Bussel: Yes. Mr. Hurst knows that we're here. He couldn't be here today. He's in Winnipeg, in Manitoba, and he asked us to present on behalf of a leadership group that works provincially with regard to seniors' mental health needs, including SHRTN.

The Chair (Mr. Kevin Daniel Flynn): Very good.

Dr. Lisa Van Bussel: All right. So I'll go ahead and start. You have a handout, and I'm hoping we'll have a little discussion at the end.

I am presenting on behalf of our leadership group, which is part of a provincial leadership group for seniors' mental health outreach teams, as well as specialized clinicians that work with seniors who have mental health illnesses.

We know that you've already talked to individuals with lived experiences and with other organizations that have represented various faces of seniors' mental health issues, including the Alzheimer society, the Ontario Seniors' Secretariat. You've heard from CAMH and the mental health commission. We're hoping that this will build on the previous presentations you've had in the last several weeks.

We want to thank the committee for not only allowing us to speak today but taking on the opportunity to learn more about mental health issues across the lifespan.

So why are we here? Julia and I are here to help review, reinforce and highlight some of the important demographic issues for seniors with late-life mental health issues; the impact of mental health on seniors and their families, in particular that in late life there usually is mental health in context with medical illness, increasing disability and a range of psychosocial issues, which means maybe changes in their life—moves, losses, those kinds of things. We want to help you recognize some of the obstacles in terms of what we're currently working with, and service gaps. Julia will then talk about three

opportunities for transformation for our health care system.

For many of you, you may have already understood from the previous presentations that seniors suffer from an array of mental health issues and illnesses, including depression, anxiety, psychotic disorders and addictions. Also, there is evidence of emotional, behavioural and cognitive complications of many brain disorders. You've heard about Alzheimer's extensively in the past presentations.

What we do know, especially for those of us who are clinicians and practitioners in this area, is that people present with very different faces when they have mental health issues and problems. We may know a lot about dementia, but an individual may present with depression when they have dementia.

So why is this important to understand? Seniors with late-life mental illnesses are, unfortunately, in a unique and complex situation. One of the slides on page 5 outlines a number of areas that I'm going to highlight briefly.

1810

You may have already heard about the stigma and discrimination against those individuals with mental health issues. Older adults have double jeopardy: It's the ageism and the mental health stigma that often prevent or result in lack of identification, lack of health promotion, prevention and treatment of these issues. The other part that is very clear from our working in this area is that seniors themselves buy into the stigma and the myths of aging and often will not understand or appreciate the importance of early identification and treatment.

There is a real diversity and difference in demographics. Individuals, as they age, present very differently; this is not a homogeneous group that we're dealing with. As a clinician, I can tell you that. The issue is very complex and there's a lot of chronicity with illness. We need to understand the context that people are living in. Again, to reinforce that, often there is a hidden or unrecognized illness, and it's very difficult for clinicians or the health care sector to get them into treatment.

There is also a concern around threshold. Individuals with mental health problems often have multiple areas of vulnerability. That also often increases the risk to themselves and to others. For example, an individual who has a mental health problem may have difficulties driving, so there may be a risk to themselves and to the community. They may have an increased suicide risk. They may have increased frailty from their medical problems. So you can see, as there are mounting issues, there may be quite a significant increase in risk.

Working with older adults with mental health and medical issues, we know that it takes a lot more time to help assess the problem and help to develop a plan, and that plan often includes not only the individual, but their support system and their family. We are wanting to be more proactive in dealing with this, but often, what practically happens is that we're in a reactive situation of

trying to do things more quickly and cut corners, and in the end, we don't have as good an outcome as we'd like.

Just to review a little further, older adults often are at higher rates of mental health issues; one in five older adults may have a mental illness. Despite this high prevalence rate it's often under-recognized and under-treated, and 50% of those with recognized mental health disorders do not receive mental health services or appropriate treatment. Older adults frequently do not like to use the traditional mental health clinic or access their care services through the traditional kind of care.

This is kind of highlighted: It can often be very complex for older adults to access appropriate care. That includes transportation, working with their family doctor, getting to the specialist on time or working with the homemaker. There are many, many layers that may be involved with dealing with the care.

Again, to highlight, mental and physical issues are very common in older adults. Eighty-two per cent of those over 65 may have one or more chronic conditions; 43% may have three or more. We know that this is often seen through their primary care office; 80% of the primary care visits and 67% of all hospital admissions are for a chronic condition.

How does this fit with mental health disorders? The following slide is a bit more pictorial for you to take one example. For example, depression is very common among individuals who have a stroke. There's a very high prevalence rate of depression after stroke. We know that individuals with diabetes also have a high risk in rates of depression and so forth and so on. You can see that even for one example, there are a lot of concurrent medical and mental health issues.

This is a very simplified way of presenting this to you. On top of this, if you start to look at the psychosocial losses or changes for some older adults, you can see that it becomes a very complex picture for those individuals.

Why is this important to understand and review? We know that currently, many of these individuals have poor quality of life, increased morbidity or poor health outcomes from their medical issues, and there's often an increased reactive approach to individuals who come for care. We may only be looking at the medical issue, but not really treating the mental health issue that may actually be exacerbating the medical issues.

What we'd like to do now is have Julia speak on some approaches and concepts that we have that may help transform our health care system.

Ms. Julia Baxter: Hi. My name is Julia Baxter. I'm the manager of geriatric mental health outreach programs at St. Joseph's Healthcare in Hamilton. I'm also co-lead for a community of practice with the Seniors Health Research Transfer Network, SHRTN.

Thank you very much, Lisa. I think Lisa gave us a great overview of why we're here and why we need to have some considerations when we're looking at mental health and addictions and looking at the population of seniors.

So how can we help? We believe that in our roles as clinicians, educators, administrators etc., we have opportunities and responsibilities: firstly, to look at the evidence, be it a randomized controlled trial or even just an experience of one. We have a responsibility and an opportunity to see what we can learn from this. Can we apply it? Does it catalyze the need for more exploration or more research?

Another opportunity or responsibility is to reflect, acknowledge and seek experience. That experience is from multiple perspectives, be it the lived experiences of seniors and their families to those paid and unpaid caregivers surrounding them.

I guess thirdly is looking at the opportunities and responsibilities for us to consider how best to enable and promote exchanges: exchanges of information, of knowledge, of ideas and resources. Those could be at the individual level, at the team organization level or the system level. We would be doing all of that, trying to put together evidence, experience and exchange, knowing and recognizing the senior at the centre.

More specifically, what needs to be done? In spite of the efforts of dedicated professionals, a fragmented service structure has developed over time. In some cases, it is not the absence of services that is the challenge, but rather it is a lack of coordination, integration and accountability. In other situations, it may be a lack of adequate supports or services that has created a service gap in our delivery system.

What needs to be done? We're suggesting for people to consider implementation of a framework, a framework that fosters integration, coordination and collaboration across a continuum to support the needs of seniors and families. We want people to review earlier work that holds great possibilities and directions; so, build on existing solutions and efforts.

We bring to your attention three documents. There could be more, but these are three documents that are out there—dedicated work has gone on in our province over time—one being Building a Better System, which was developed in March 2007, a report that examines the components and approaches required to care for residents in long-term-care homes in Ontario exhibiting aggressive behaviour. Another document, Specialized Geriatric Mental Health Outreach Teams Policy and Accountability Framework, again, is setting the policy stage for more than 60 teams that exist within Ontario today. A third example of previous work is the Canadian Collaborative Mental Health Initiative. That federal initiative created a tool kit for planners and providers establishing collaborative initiatives between mental health and primary care services looking at seniors.

Many service components already exist in a greater or lesser degree, depending on a range of local factors. It could be the location; it could be resource availability, the local context or demands. What we're promoting for people is, if a framework were to be developed, we could explore whether it is a lack of coordination, integration and accountability, or if there's truly a service gap. One

of the service gaps that we do know exist across the province is higher-level immediate care—possibly looking at the promotion of services to support seniors in community or long-term-care settings. A responsive policy or operational framework will help to define necessary service elements and create alignment in a provincially consistent, locally appropriate direction.

What else needs to be done? Delivering direct service is not enough, so we're asking for an investment in those services that practise a triple-hat mandate. What is a triple-hat mandate? Well, the breadth of stakeholders involved in determining seniors' health is not sufficiently recognized. There's a lot of people who go into trying to support a senior with mental health and/or addictions or behavioural issues. What we need is partnership in collaboration. Needs being met is a very complex affair with many dependencies. The interplay between knowing and doing and being able to do is key. What we're looking for in the triple-hat mandate or the triple-hat practitioner are individuals, organizations or systems that are committed to that clinical shared care but also to learning and development and looking at the developing of partnerships and alliances that bring community or system development all together. That interplay will create a multiplier effect and some synergy. The impact can be felt across systems and sectors, be it community, long-term care or hospital, health or justice, mental health or addictions.

Even now, when we actually look at priorities to promote ER diversion, inappropriate presentation at the emergency department or trying to move our individuals from acute care, we hear a lot about ALC. Looking at that triple-hat mandate, not just the clinical care but the education and system development, can help move us together in alignment. Ontario's geriatric mental health outreach teams have that triple-hat mandate. They are seen as a resource to transform the system for seniors.

Thirdly, what else needs to be done? We need to strengthen the support mechanisms for knowledge transfer and exchange. There's a limited pool of professionals across sectors that possess specialized formal training in seniors' health. We need to build linkages. We need to build on people's inherent want to provide good care. We need to lever existing mechanisms at the individual level; it could even be client self-management or it could be at the individual level, as it relates to a staff person, a team, an organization, a network or the system.

We have examples in our province today that we would like to say are good examples. Ontario had an Alzheimer's strategy, and it created more than 50 psychogeriatric resource consultants who are scattered across the province. These individuals have the mandate where they look at doing staff development in long-term care, at CCACs, in adult day programs and supportive housing. Again, they're reflective of the multiple settings; you will find them in the multiple settings where you would find seniors affected by mental health and/or addiction issues. We need to foster innovation with respect to knowledge transfer and exchange.

The second example is SHRTN. I want to highlight SHRTN as an innovative and responsive network of people involved in seniors' health. Through effective use of technology, knowledge brokers, information specialists, communities of practice and research networks, it connects people to knowledge, to expertise, to ideas, to innovations and research; it inspires, and it can actually do that and I don't even have to leave my office.

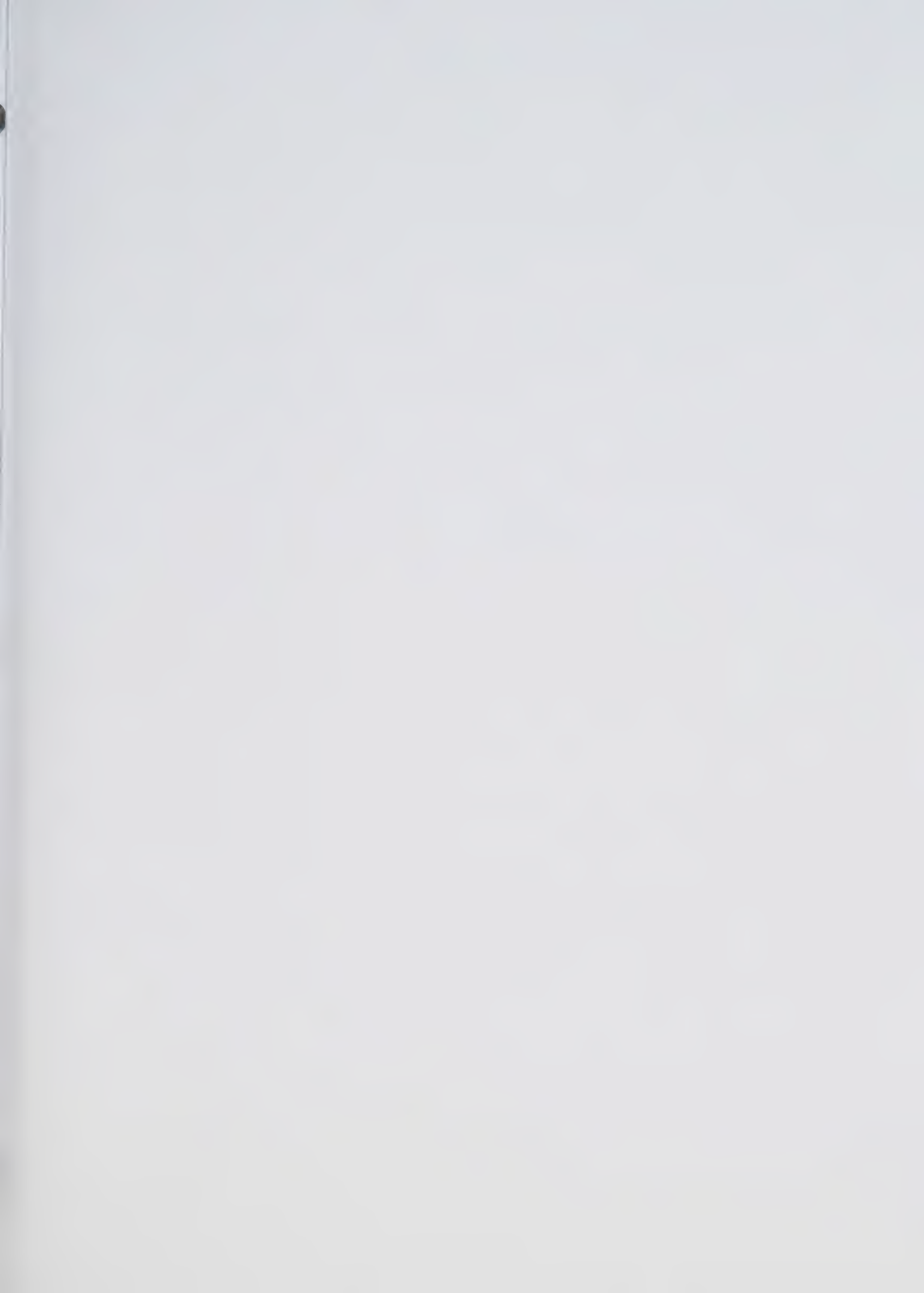
In conclusion, there are many avenues or directions this committee, the advisory group or the government may choose to take to enable and ensure the achievement of the collective vision: Every Door is the Right Door. From evidence, experience and exchange, we encourage you to consider and reflect on the development and implementation of a framework, the investment and

promotion of a triple-hat mandate, of strengthening and supporting knowledge transfer and exchange. We believe that if you were to consider these directions, we may be able to collectively create and sustain synergies to achieve better health for seniors affected by mental health, addictions and behavioural issues.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for a great presentation. Unfortunately, you used up all your time, and actually, a little bit more, but I think your presentation was very clear. I'm sure all members understood what you were talking about. Thank you for coming today. It was really appreciated.

For the committee members, we're adjourned.

The committee adjourned at 1820.



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Mercredi 18 novembre 2009

Select Committee on Mental Health and Addictions

**Mental Health
and Addictions Strategy**

Comité spécial de la santé mentale et des dépendances

**Stratégie sur la santé mentale et
les dépendances**

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**SELECT COMMITTEE ON
MENTAL HEALTH AND ADDICTIONS****COMITÉ SPÉCIAL DE LA SANTÉ
MENTALE ET DES DÉPENDANCES**

Wednesday 18 November 2009

Mercredi 18 novembre 2009

*The committee met at 1609 in committee room 1.***MENTAL HEALTH
AND ADDICTIONS STRATEGY**

The Chair (Mr. Kevin Daniel Flynn): If I can ask all the members to take their seats, please, and perhaps we could close that door. Thank you. I'd like to welcome everyone to the Select Committee on Mental Health and Addictions. Our apologies for starting a little late.

The bells may be ringing throughout the afternoon. If you see the committee up and run out the door, don't take it personally; we're going into the House to vote, and we'll be back, hopefully, in five or 10 minutes. It may delay proceedings a little bit; I hope not too much.

FAMILY SERVICE ONTARIO

The Chair (Mr. Kevin Daniel Flynn): With that being said, we're going to start with our first presenter of the day; that's Family Service Ontario, John Ellis. John, if you'd like to make yourself comfortable—anywhere you're comfortable in that front row there.

Mr. John Ellis: There are two of us.

The Chair (Mr. Kevin Daniel Flynn): That's great. Come on forward. Make yourselves comfortable. If you could introduce yourselves when your time begins.

What we've done in order to accommodate as many speakers as possible is that everybody is getting 15 minutes. John, you and your colleague can use that any way you see fit. If there is a little bit of time at the end for some questions or discussion, that seems to work well as well, but that's entirely up to you. I'm going to turn it over to you, John, and then, if you would introduce your colleague as well for Hansard, we can get going.

Mr. John Ellis: Will do. Thank you very much. I'm John Ellis, and I'm executive director at Family Service Ontario. With me is Rebecca Roy, who is a program manager at Lutherwood in Kitchener.

I'm going to speak to you first, and then Rebecca will take over after I'm finished my portion of it. We'll try to go as quickly as we can within the time limit and allow for any questions that you might have.

First of all, I'd like to say how pleased we are to have this opportunity to share a vision for mental health and addiction services in Ontario with you. We applaud the government for taking these steps towards an integrated

and responsive system. It's not an easy task, we know that, with so many different ministries and departments involved in the system.

We're going to give you some background, first, from the Family Service Ontario perspective and introduce you then to an exciting model of coordinated local services that's currently operating, as I mentioned, in the Kitchener-Waterloo area that we would like to see replicated across the province.

First of all, about family service agencies: These are 40 to 50 family service agencies, as many of you know, that are situated in communities all across Ontario and integrated with services at all levels of the service delivery system. They are major providers of family counselling to individuals, couples and families with mild to moderate mental health problems.

For those people who experience anxiety and depression from family breakdown, job loss, addictions, parenting challenges and domestic violence, family service agencies are there to help. Referrals come from family physicians, mental health clinics and local hospitals, workplaces, schools, police, children's aid societies and other organizations, such as the Canadian Mental Health Association, children's mental health organizations and many others. Ideally, these referrals come before a crisis occurs.

The services of family counselling agencies mitigate the high costs of unnecessary emergency room visits in hospital and the involvement of more expensive mental health specialists. At the family service agencies, there are highly trained, experienced staff, primarily social workers, who provide a broad range of individual and family counselling services in person and over the phone, who help people of all ages and walks of life resolve their personal issues, become better parents, deal with their drug and alcohol problems and function more effectively in the community. In addition, family service social workers contribute to cost-effective outcomes through their collaborative case management skills.

Family Service Ontario sets accreditation standards as well for the organizations that are part of the network to ensure that they not only have high-quality service programs but the agency itself is run effectively and efficiently.

New data from a valid and reliable study of 2,100 clients over two years through the family service outcome measures study indicates the following: 60% of

individuals seen by family service agencies with a moderate mental health problem show significant clinical improvement as a result of treatment intervention; 98% of individuals who are under stress improve their ability to participate in the workforce; and family counselling services were found to be twice as effective as the average treatment for common mental health problems.

Currently, family service agencies are situated in what we call the second tier or level of Ontario's referral process for the delivery of mental health services. This is a level that is often forgotten by the government, where those who are most emotionally and financially vulnerable receive the least funding support. In contrast, services to individuals who enter the system through what I'm going to describe for you as levels 1 and 3 are funded primarily by the Ministry of Health and Long-Term Care.

Level 1: These are individuals who visit their family physicians and mental health clinics in hospitals. This is the level where the doctors are compensated by the province even if no service is provided, even if they make a referral out. That's level 1. It's like the primary level of contact for an individual who goes to their family doctor who realizes that there's a problem and will refer them.

The second level includes the family service agencies to which many doctors do make referrals. There are other referral sources to family service agencies, as I mentioned, but this is a sort of second level of intervention. A person has a problem, they go to the family doctor, and then they get referred somewhere else if they have been determined to have a mental health issue. Sometimes that's to the family service agencies, which is that second level, and sometimes it's actually to what we describe as the third level of intervention, which is the more specialist intervention, so they go to see a psychologist or go to see a psychiatrist.

1620

Most people can't afford to pay a family service agency's full fee, so the agencies essentially cobble together the various resources that they have, various funding, to try to provide the services. But rarely does any financial support come with these referrals that I'm telling you about. No matter where these referrals come from—they come from all over, various sources, whether it's the CAS, whether it's a family doctor, whether it's Ontario Works or another agency—no funding comes for the service that's being requested. In fact, what I'm trying to explain is that levels 1 and 3 are much better funded levels of intervention. Doctors are paid through OHIP, and so are psychiatrists, which is level 3. People who are referred to psychologists have to pay for themselves out of their own pocket. It's that second tier of intervention for people with mental health problems, the tier in which the family service agencies fall, that is an issue for us, because adequate funding does not come with the individual referral.

Rebecca is going to talk to you today about a model which we think resolves this issue. It only exists in one part of the province, and we would like you to study this

model if you're not familiar with it already, because we think it has great potential for future rollout throughout the province. It's a partnership of six community counselling agencies called Health-Connect Counselling Partners, coordinated through the mental health system by Lutherwood. It's a community-based and outcome-proven collaborative of local community counselling agencies, which includes family counselling agencies, doctors, hospitals and other service providers, that aligns perfectly with the key concepts promoted in the Ministry of Health's discussion paper *Every Door is the Right Door*.

Again, we encourage the government to scrutinize this model carefully. Family Service Ontario and Health-Connect partners are ready to work with the government towards its expansion. We believe it will save the system money immediately, rationalize referrals, reduce wait times through inappropriate visits to specialists, hospitals and clinics, and ultimately serve those in need more effectively and more efficiently.

Here to give you some more details about that program and how it works is the program manager from Lutherwood, Rebecca Roy.

Ms. Rebecca Roy: Thank you very much, John.

The Chair (Mr. Kevin Daniel Flynn): Just so you know, Rebecca, you've got about six minutes left.

Ms. Rebecca Roy: Okay. I will try to be very concise.

The Chair (Mr. Kevin Daniel Flynn): Relax; just so you know.

Ms. Rebecca Roy: Thank you very much for this opportunity to come and talk to you today. What I'm going to be telling you about, as John told you, is our model that combines universal primary health care focusing on mental health and addictions. This is a model that exists only in Waterloo region, and we're hoping that with some understanding, this model could evolve across the province.

Our program has been operating since December 2005. We're currently funded in Waterloo region for patients of family health organizations. With the program, what can happen is that adults, children, couples or families who are experiencing mental health or addiction challenges have the opportunity to receive early treatment and intervention. What we've done is integrated mental health, addiction and physical care. What happens is the person, whether it's a young person, a child or an adult, experiences a problem. It may be very simple or it could be a little bit more complex, with combined aspects of mental health, addiction or physical health. What would normally happen or what happens in our region is that you go to your family doctor for primary care and have the opportunity to speak to him about that. The family doctors who are participating in our program can make a referral to a centralized service, so we provide counselling services, we provide psychiatric consultation, and we provide psycho-educational assessments and other psychological services.

Our intake is centralized. We have only one phone number, one fax number. In our region, we currently

serve approximately 12 family health organizations with 50 practitioners.

As John told you, we have six partner agencies. We have approximately 12 full-time counsellors and intake workers coming together from various counselling agencies in our area. Mental health and addiction counselling are provided at one family medical practice location and at other community locations across the region which are operated by our six partner agencies.

We are in both urban and rural settings. We're very accessible. We provide clients with more than 35 therapists and clinicians with diverse clinical areas of expertise and different languages and cultural backgrounds, which greatly enhances the chance of having a good fit between the client and the practitioner.

As I said, we also have psychologists who are available to do assessments and other consultations, and we have a small piece of a psychiatrist, who is available to us every Thursday afternoon.

We think this simple model could really be transformed. Many of our citizens in Waterloo region don't have access to a family doctor, so our vision would be something that would open up more partners in the program. More referral sources could be added. We could include other family doctors, urgent care clinics—we have two universities in our region where they have clinics—hospitals, and other community agencies or self-referral.

The idea is that with increased referrals, service delivery would expand for a wider range of service providers. In our community we could add in another hospital, other counselling agencies and other community agencies that focus on substance and process addictions, and we could also include organizations providing interventions and support for women experiencing violence.

This relationship with our local self-help peer support group could also be formalized. I know there's a movement towards more self-help programs.

We could add housing; we could add employment services. In Waterloo region, Lutherwood provides both of these services.

Whereas the current system is based on funding envelopes with many government funders from three different levels of government and different ministries, what we could do now is look for a new way to imagine how the system could look. Our Health-Connect model is a flexible, responsive funding system which responds to local collaboration. It's based on local solutions that are holistic and community-based. It began with a proposal created to meet local needs. Government departments could collaborate in response to design and provide appropriate funding.

Thank you very much for this opportunity. I'd like to let you know that we've created a submission for you. We had a PowerPoint, which unfortunately we couldn't share. The highlights are in the centre for you.

The Chair (Mr. Kevin Daniel Flynn): That's wonderful. Thank you, Rebecca, and thank you, John. That's great time management: You left about 45

seconds. It's probably not worth even starting on a question, but thank you very much for the thorough—

Ms. Rebecca Roy: Thank you for the opportunity.

M^{me} France Gélinas: I have one quick question.

The Chair (Mr. Kevin Daniel Flynn): Yeah, I've seen quick questions before. Okay, try it.

M^{me} France Gélinas: What is your budget right now? How big is it?

Ms. Rebecca Roy: I think we're looking at just over \$2 million.

Ms. Sylvia Jones: Who gives it to you?

Ms. Rebecca Roy: A variety: the Ministry of Health and Long-Term Care and other region—

Mr. John Ellis: Do you mean the Health-Connect budget or the Lutherwood budget: the organization's budget or this program's budget?

M^{me} France Gélinas: This program.

Ms. Rebecca Roy: Oh, I can speak to that. It's just over \$1.3 million. My apologies.

The Chair (Mr. Kevin Daniel Flynn): Thank you.

M^{me} France Gélinas: And it—sorry.

The Chair (Mr. Kevin Daniel Flynn): I'm trying not to be mean.

Okay. Thank you very much for coming. That was appreciated.

1630

GESTALT INSTITUTE OF TORONTO

The Chair (Mr. Kevin Daniel Flynn): Our next presenters today are JoAnne Greenham and Yvonne Brunelle, if you'd like to come forward. Make yourselves comfortable. You were here when I explained the rules the first time, so the same rules apply to you. Relax. There are some clean glasses and some water there if you need any.

Ms. JoAnne Greenham: Take my time and drink water? Not a chance.

Laughter.

The Chair (Mr. Kevin Daniel Flynn): Well, the time is yours to use as you see fit. If you would introduce yourself as well, for Hansard.

Ms. JoAnne Greenham: Thank you for this opportunity, everyone. I'm JoAnne Greenham, executive director of the Gestalt Institute of Toronto. With me today is Yvonne Brunelle. We'll introduce you to her program a little later on.

We were founded in 1970. We're a small but mighty little institute. We're a non-profit educational institute registered with HRDC. We offer personal development programs to the public and professional training in leadership and psychotherapy to professionals of all kinds. My experience is in consulting, training and supervising professionals of all sorts, and I've written those down in your handout.

Our students learn from the inside out. They are members of a group continuously throughout their four-year training program. After two years of intensive personal therapy, they learn to apply their skills to leadership that

is quite clear of their own neurotic needs. They learn to utilize feedback graciously and skilfully.

Exerting opinion onto and influence over clients is not the job of the therapist, we believe. They do not impose their values and ambitions on the clients; they learn to work with how the client is stuck.

The strength of our program is in the length and the depth to which all of our graduates are trained. They emerge as individual and group psychotherapists. Also, they're trained in co-leadership skills, a component of training that is unique to our model. This training is very challenging and creative. The students are able to adapt their skills to many different contexts, from the therapy room to the classroom, to organizations and to community groups. The value of this experiential learning model is that individuals move from victims who protest their circumstances through a process of embracing who they are and what they can do.

We urge the committee to advocate for more in-depth training for group therapists in mental health and addictions. This would enhance treatment outcomes for current programs. There is no doubt that staff training enhances their motivation, confidence and effectiveness. Most of you acknowledge the benefit and expedience associated with group work. Much time is taken in planning and delivering the content of group materials, but not in developing skills for managing the process; that is, the interaction between group members.

I just wanted to mention that we use empowerment of the client as a basis for our values, and that involves responsibility, risk-taking and emotional attachment.

We urge you to recommend the allocation of funding for more ongoing experiential learning in the areas of diversity, cultural identity, change management, trauma and abuse, and personal growth in schools, universities and community-based programs. The Gestalt Institute is available to consult around any of these issues.

Consumers of all ages are able to choose for themselves already on anger management, self-esteem, depression and anxiety programs based on models for self-support and change. We offer programs that focus on the human condition. This kind of approach has a role in prevention and in the maintenance of a healthy relationship-based lifestyle. Some people in society are motivated to take responsibility for their health and for personal problems and they're willing to pay directly. This programming can divert traffic, appropriately, away from expensive treatment in the overloaded health care system.

I just want you to consider for a moment programs entitled:

- anticipation, which is a program on anxiety;
- the trouble with anger, which attracts all kinds of people; and
- beyond belief, a program on diversity.

As a value, we would agree that empowerment and awareness are important aspects of treatment for survivors of abuse and trauma.

We recognize the need for a reinforcement of services for groups from First Nations communities, the elderly,

children and youth. We are familiar with the psychiatric and addiction problems so often accompanying survivors of trauma. We believe that their recovery requires a gradual development of healing, support, responsibility, integrity and culpability, and the experience of being valued in their relationships. We're available for ongoing training both on-site and off-site.

Our students come to us from many different backgrounds. Many organizations choose to support their staff financially for the cost of the training. One such graduate is with us today. I am delighted to introduce Yvonne Brunelle from the Enaahitig Healing Lodge and Learning Centre in Victoria Harbour, Ontario. You have some of her program materials with you. She has integrated the Gestalt model over the four years of her training in her approach to healing and has effected a profound impact on her clients and her community.

I've included a summary at the bottom of my handout but I would like to invite questions for Yvonne and for myself, if you have any.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much. You've left a lot of time for questions. It looks like we'll have about three minutes for each party, starting with Christine or Sylvia.

Mrs. Christine Elliott: Perhaps Yvonne could tell us a little bit about the programs that she's responsible for and how the Gestalt approach has helped you with that.

Ms. Yvonne Brunelle: Sure. I work at an agency. It's off-reserve and we're funded through the aboriginal healing and wellness strategy as well as the Aboriginal Healing Foundation. Primarily, my work is with residential school survivors and intergenerational trauma, so working with clients who have complex trauma. My title there is senior counsellor; I oversee the residential treatment as well as the other counsellors who work within the residential treatment program.

Why I chose to get further training through the Gestalt Institute was, I did lots of research when I was considering training, and the Gestalt Institute could offer what I felt was the most compatible approach to what I was already doing. I've been working at Enaahitig for nine years. It's a holistic approach. When working with clients with complex trauma, they're looking for authenticity, and that's what the Gestalt Institute could offer me and support what I was already doing.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Christine. France?

M^{me} France Gélinas: First is, if it takes a long time, don't answer it because I have other questions, but the name is weird. Where does it come from? What does Gestalt mean?

Ms. JoAnne Greenham: As my son once said when he was very little, "It means 'the whole.'" That's what he used to tell people. But Gestalt comes from that notion that one plus one is more than two. It really comes out of those days of beginning to treat the patient as a whole and the holistic movement in the early part of the century.

M^{me} France Gélinas: How much would the four-year training cost? Maybe I can ask you: How much did it cost?

Ms. Yvonne Brunelle: I was fortunate because my workplace paid for my first year. I'm a status Indian, so Indian Affairs paid for the remainder of my training. But I think it came up to \$6,000, \$7,000—I'm not even sure—

Ms. JoAnne Greenham: I think it's \$12,000 now for the four years of part-time training.

Ms. Yvonne Brunelle: And then there's clinical supervision throughout, and therapy.

M^{me} France Gélinas: And are you recognized by the Ministry of Training, Colleges and Universities?

Ms. JoAnne Greenham: That's a big question that we're looking at right now. Because we're approved of by a higher level, we've been registered with HRDC for a long time, so we're investigating that with the college now to find out what the overlap might be and what the possibilities might be to be dually registered.

The Chair (Mr. Kevin Daniel Flynn): Thank you, France. This side? Maria?

Mrs. Maria Van Bommel: Yvonne, how do you reconcile the traditional aboriginal healing and the Gestalt method? Are they compatible? How do you work with other aboriginal people if they're looking for the more traditional type of approach?

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Ms. Yvonne Brunelle: I would say that they are compatible. When working within the aboriginal community, I would say that the clients are looking for someone, first, with cultural competence, so someone who has knowledge of the traditional ways. Second, they're looking for someone who has done their own personal work. Again, working with complex trauma they can see whether you're authentic or not or whether you're walking the talk, and in the aboriginal community that is so important, which is why, with traditional elders and traditional people, having done that piece of their own personal work is so important. Within the Gestalt Institute I've been able to do that for myself along with the work I've done at the healing lodge, so that's where it comes in. Then again, the approach is that you're working with what is, with the client, not imposing your agenda, and that definitely goes along with the philosophy of the traditional ways.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today. It was a great presentation. We really appreciate it.

KATHY BAKER

ANN TASSONYI

The Chair (Mr. Kevin Daniel Flynn): Our next presenters are psychogeriatric resource consultants Kathy Baker and Ann Tassonyi, if you'd like to come forward. Make yourselves comfortable. You have 15 minutes like

everybody else; use that any way you see fit. If there's any time at the end, we'll split it.

Ms. Kathy Baker: Okay; great. We're grateful for the opportunity to present to you today the perspectives as experienced by the many doors entered by the psychogeriatric resource consultants in the province of Ontario and we applaud you for your work towards a 10-year mental health and addictions strategy. I'm Kathy Baker, the psychogeriatric resource consultant for Hastings and Prince Edward counties, and my esteemed colleague Ann Tassonyi is the psychogeriatric resource consultant in the Niagara region. Both Ann and I have been in the PRC position since its inception in the province of Ontario.

The PRC positions were one of the 10 initiatives under the Ontario government's Alzheimer strategy from 1999 to 2004. The plan was to put in place 50 full-time-equivalent PRC positions that would support the staff in the long-term-care system, both the long-term care homes and community agencies who are providing care for those older adults with complex cognitive and mental health needs and the associated behavioural challenges that are so often accompanying those mental health needs. We've become known as the triple-hat practitioners in the province of Ontario.

The three hats that we wear: In each of our regions, the PRCs support staff in the long-term-care system when they're faced with those highly complex situations by way of education; so both case-based education and topic-specific. Many of us in the province are provincial PIECES educators, and the PIECES education model was supported also by the Alzheimer strategy—gentle, persuasive approaches in dementia care, just to name a couple.

By way of consultation, we provide case-based consultation and care planning consultation for those clients who are presenting with those highly complex cognitive and mental health needs. Consultation may also be for projects as well as policy development within organizations as well. The community development activities that the PRCs are involved in in each of the regions would be broader community activities and conferences as well as network developments. In each of our areas in the province, we've developed dementia networks.

So our focus as PRCs in Ontario is to improve the quality of life of seniors with complex cognitive and mental health needs by enhancing the capacity of the front-line staff; supporting human resources in their continued, person-centred work with these highly complex individuals, increasing knowledge at the bedside, so increasing the knowledge of point-of-care staff; transforming the system to foster linkage collaboration across the system so that the transition of these folks is seamless; and increasing access to specialty services and ensuring efficient use of these resources.

Some of the seniors' mental health issues that we often see in long-term care and in the community agencies where we provide staff support and education consultation are mood disorders, depression, bipolar disorder, post-traumatic stress, anxiety disorders, psychotic

disorders—both lifelong psychotic disorders such as schizophrenia or late-life presentations such as paranoia—and addictions issues, and the many forms of dementia and the behavioural and psychological symptoms that often accompany those.

Why are we here? I'm not going to go over lots and lots of numbers because the numbers are staggering, and they speak for themselves. I'm sure you've been presented with many numbers. The Canadian Coalition for Seniors' Mental Health say that by the year 2021, 18% of Canadians will be over the age of 65 years, and 45% of this group may be over the age of 85. In your document, *Every Door Is the Right Door*, you mention that, "Ten to 25% of seniors experience mental health disorders," and by the age of 80, one in three of us will be affected by some form of dementia. The prevalence of mental health disorders in long-term-care homes in Canada is between 80% and 90%; that's from the Canadian Coalition for Seniors' Mental Health.

The needs of the long-term-care system, as the PRCs in Ontario see it: We need to focus on mental health and mental illness. We need to recognize the diversity of these clients and also the complexity. An interdisciplinary approach to support these highly complex clients is so very important. The collaboration and linkages in the continuum of care are also very important. We need a knowledgeable workforce that has the capacity to provide the social and physical environment to support clients with mental health and addictions issues.

Ms. Ann Tassonyi: I'm going to continue on. I'm Ann.

As a community of practice, we got together a couple of weeks ago and looked at the themes from your strategy. We thought, "We already address a lot of these themes in our mandated role as psychogeriatric resource consultants." It was great to have a discussion about how we can further move these themes forward in our local communities and institutions. We thought about how we can help with the strategy.

We really do think we do help people act early. We're always teaching people about person-centred care in our case-based consultations and our education programs, looking at early identification and trying to reduce stigma.

We often in long-term care find that people think people with mental health disorders do not belong in long-term care. We'll always have people saying, "Well, he's mental health," or, "They're schizophrenic. They belong in the provincial hospital." Unfortunately the provincial hospitals have reduced their beds to the point where we have to manage people in our own community unless they really have behavioural problems that are very difficult to manage and really exceed the resources that we have.

We are trying to enhance the capacity of the workforce. We're involved in development of best practice guidelines, dissemination and implementation of guidelines such as the registered nurses' association guidelines on screening and management of dementia, delirium and

depression. We've been involved in dissemination and implementation of the Canadian Coalition for Seniors' Mental Health guidelines to increase best practices in the long-term-care system.

We do pre-licensure education for personal support workers in colleges. We mentor students in the long-term-care system. We do a lot of on-the-job training and also postgraduate education. For instance, a program at McMaster, the clinical behavioural sciences program, which is a postgraduate diploma program, has a geriatric mental health component to it. There are other universities around the province that have similar things that we are involved in. As part of our job in education, we are linking with other professionals. We're collaborating, forming partnerships and always trying to get the people who are working with complex adults to make referrals, pull in palliative care, stroke experts, pastoral care, geriatric psychiatrists, geriatric medicine—whatever is needed in the complex system.

1650

In our consultation role we do case-based consultation. One of the things that is important in long-term care is that there are many unregulated staff. The way they get their information is by talking to each other, and that has been shown in the research. Also outreach and coaching has been shown in the research to be an effective method of knowledge transfer.

We've been involved with universities such as in the Murray Alzheimer Research and Education Program; McMaster University in terms of piloting and evaluation of, for instance, a gentle persuasive approaches workshop; and best practice implementation activities, as I mentioned before.

Again, we're trying to strengthen the workforce, getting people to identify persons who have capacity issues or consent issues, use best practices and certainly try to evaluate what we're doing and collaborate with researchers in the field of aging.

In our community development role, we're also working with many caregivers across a continuum of care, especially—Kathy mentioned the dementia care networks, which were actually given some seed funding a few years ago when they looked at the research done by Dr. Lemieux-Charles at U of T. Larry Chambers and Ken Le Clair were involved in evaluating networks and their efficacy, and it was deemed appropriate for dementia care networks to be supported across the province. That funding hasn't recurred. There were requests for proposals twice and they have not been supported since then, but they're an important way to draw people together to identify gaps and build capacity in the system locally, regionally and provincially, because the networks have banded together in the LHINs and also provincially to move forward the issues facing the elderly population.

I think that the cross-sector collaboration and linkages are really important and we do support those. Hopefully, we are helping to transform the system with those efforts. In terms of what needs to be done, we're hoping that the Minister of Health and Long-Term Care will invest in

specialty geriatric services. We certainly need increased access to specialty services, outreach programs for people who can't access services or won't access them because of mental health difficulties, case management for public health, outreach services, community care access centres—they're all stretched. We need more triple-hat practitioners such as us, the psychogeriatric resource consultants. We have large areas of responsibility, and certainly helping people implement best practices is a challenge with the large numbers that we face.

There are other services that really enhance the care of the elderly, such as geriatric emergency medicine and nurse practitioners who also span long-term care and acute care. These kinds of things will all prevent admission to the ER and long-term care and save the system some money.

The other thing that's very helpful is sustained funding for knowledge transfer activities such as through the Alzheimer Knowledge Exchange, the Seniors Health Research Transfer Network and funding to organizations such as the Canadian Coalition for Seniors' Mental Health and the Registered Nurses' Association of Ontario that actually disseminate and facilitate implementation of best practices across the systems.

Also, the Stroke Network and Palliative Care Network have received sustained funding for knowledge transfer activities, and that's something that we can certainly use to facilitate education. We're funding coffee and doughnuts out of our own pocket to get people to listen to us.

The Chair (Mr. Kevin Daniel Flynn): Where are they?

Ms. Ann Tassonyi: I really forgot those doughnuts.

I think that's—hopefully, if anybody has any questions.

The Chair (Mr. Kevin Daniel Flynn): Good. You've left a little bit of time for questions. France, did you have one?

M^{me} France Gélinas: Where are you located? As in, I understand there are 50 of you. Do you work as part of a team or are you all alone, servicing a geographical area?

Ms. Ann Tassonyi: Originally, when the positions were funded by the ministry, there were requests for proposals for community collaboration. There are 50 of us serving geographical regions, and some populations—for instance, I think Toronto region has five—

Ms. Kathy Baker: Eleven.

Ms. Ann Tassonyi: They have 11. In the Niagara region, we have two. But for instance, in the Niagara region, there are 32 long-term-care facilities, plus I don't know how many provider agencies. It's a lot. I don't know, Kathy, how many you have.

Ms. Kathy Baker: We cover a geographical area, and each PRC, or psychogeriatric resource consultant, is sponsored by an agency. Myself, I'm sponsored by Providence Care Mental Health Services, a geriatric mental health outreach team. Ann is sponsored by an Alzheimer society in Niagara region. Other PRCs are sponsored by CCACs, but we cover a geographical region.

Ms. Ann Tassonyi: One of the PRCs did say to me that in different areas, the funding has been used in different ways, and they were worried about the use of the funding, not maintaining the positions. So they may receive the funding, but they've been asked to do case management instead of education, so it is useful.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for your time today. It was a great presentation.

ONTARIO CONSUMER AND FAMILY ADVISORY COUNCIL— CANADIAN MENTAL HEALTH ASSOCIATION, ONTARIO

The Chair (Mr. Kevin Daniel Flynn): Our next presenter today is from the Ontario Consumer and Family Advisory Council from the Canadian Mental Health Association of Ontario, Dennis Reid. Dennis, if you'd like to come forward.

Like everybody else, you get 15 minutes. Use that any way you see fit. Probably at some point, you'd like to introduce your colleague.

Dr. Dennis Reid: Sure.

The Chair (Mr. Kevin Daniel Flynn): I'm assuming you're Dennis?

Dr. Dennis Reid: I am.

The Chair (Mr. Kevin Daniel Flynn): The time is all yours.

Dr. Dennis Reid: Good afternoon. My name is Dr. Dennis Reid. I'm an Ottawa physician. I'm currently a member of the Ontario Consumer and Family Advisory Council—that's OCFAC—of the Canadian Mental Health Association, Ontario division. I will be presenting today along with my committee colleague, Earla Dunbar. We will be speaking about our personal experiences, and then we will make recommendations which we believe will improve the mental health system in Ontario from both a consumer and family perspective.

Our major recommendations are:

- early intervention: treating symptoms during the early years for a better recovery. This includes educating teachers and counsellors to recognize the early symptoms of mental health conditions and to make the appropriate referrals;

- reduce stigma and discrimination from professional health care providers. This is a significant problem;

- invest in supportive housing. This housing will require high-level support whereby people are not evicted for behaviours that are due to their mental illness, ensuring that they maintain housing, which is central to their recovery;

- reviewing privacy legislation and considering the inclusion of families in the treatment plan of their loved ones; and

- supporting the formation of a provincial family network. I'll get into the details of that in a minute.

My daughter is 32 years old. She's the youngest of four children and has three older brothers, who are all

professional men. Rebecca has a degree in social science from Western and a diploma in journalism from Algonquin in Ottawa, and up to three years ago, she was the managing editor of the Canadian Plastics magazine.

The current cycle started three years ago: anxiety, panic attacks, depression, impulsive behaviour, suicide attempts, cutting, and anger levelled at her mother, brothers and friends, who, for all intents and purposes, have abandoned her.

She saw a psychiatrist and therapist and was placed on medication. Eventually, she went on long-term disability from work. The diagnoses are post-traumatic stress disorder and borderline personality disorder.

She was admitted to CAMH on a form 1, having told friends she was suicidal. She was discharged with no planned follow-up. Since then, she has made multiple visits to emergency departments and non-medical shelters such as Gerstein, and uses crisis hotlines frequently. She had a five-week stay at Homewood in Guelph, but was discharged for acting up. You can't act up in a mental hospital.

She has been on multiple medications and developed a dependence on medications, and as a result lost her driver's licence. Her financial situation, her apartment, are in total disarray. She has moved apartments three times, has caused significant disturbances and been threatened with eviction. I hired a lawyer and we attended a hearing at the Landlord and Tenant Board, where we settled through arbitration. She has had dealings with the police, and recently was arrested for assaulting a neighbour. She has been bound over until December 10, while we find a lawyer.

1700

There were signs of problems when she was a teenager. She had several quarrels with teachers and coaches—she was a provincial ringette player—and developed mood changes and decreased academic performance in Grade 13. These were signs of mental illness. We should have recognized them and got help at that time.

There is considerable public education on the early recognition of other diseases. Every day you get it in the mail: heart disease, stroke. The same thing should apply to mental illness. We need considerable public education.

My daughter has been admitted in crisis to all the downtown Toronto hospitals. This year, she has also been admitted to Toronto East General and Ottawa General.

I have written to all the relevant personnel at these hospitals—emergency docs, emergency heads, psychiatric heads, patient advisors—just to request that she be assessed and treated appropriately. I've been told—I've gotten replies—I am not entitled to receive any details because of privacy legislation. None of her psychiatrists or therapists have ever asked me for an interview to discuss family issues or to take a family history of psychiatric disorders or addiction. When I have requested to meet with the psychiatric team, I have been told that privacy laws preclude my input or my ability to receive information; however, I'm the first person to be con-

tacted in a crisis and am expected to bail out my daughter and the system.

The family of a mentally ill person is usually the only support left at the end of the day. They are afforded no support, no input and given little information, but expected to pick up the tab and bail the system out.

There needs to be an amendment to privacy legislation. This should state that an appropriate family history and profile must be obtained from the next of kin and the next of kin be apprised of the treatment plan and the discharge strategy wherever possible. It's not always possible.

There is an urgent need for a provincial family network to assist family members with the problems they are likely to encounter as they navigate the complex and frightening world of mental illness. Dealing with mentally ill patients is difficult and I can understand why some hospital staff have problems coping with disruptive behaviour. It's not pleasant. However, there is no excuse for trained personnel, professional caregivers, to use demeaning language such as "nutbar" and or "GOMER," which means "get out of my emergency room."

The College of Physicians and Surgeons and the College of Nurses of Ontario should issue guidelines for dealing with the mentally ill patient, and deviations from these guidelines should be reportable and subject to discipline. They've done the same for sexual abuse. Only then will we be able to eliminate the stigma attached to mental illness.

A crucial part of treatment is psychotherapy—\$150 an hour. It's not covered by OHIP. It's covered by WSIB. Insurance companies usually pay a maximum of approximately \$300 total. The cost of psychotherapy needs to be addressed by our public and private health care insurers. People with mental illness require more than just medication.

My daughter has never been referred to a social worker or any social organization for community support. Her social support is me, 480 kilometres away, and her boyfriend, who has his own mental health problems. People with significant mental illness require a designated social worker and network to help deal with the problems of daily living. This should be mandatory.

I can honestly say that dealing with my daughter's mental illness is the most difficult thing I've ever done. I've found support groups to be therapeutic; I've heard a lot worse stories than mine. I'm angry at the health care system. I'm angry at doctors and nurses who use demeaning language, but I really have the utmost respect for the few who genuinely care.

I'm angry at Homewood for discharging my daughter during a crisis and forcing her to take a taxi to Toronto at a cost of \$200 and telling me at the last minute. I'm angry at the Ottawa General Hospital who discharged my daughter home without informing me, after she had been admitted in crisis, having physically assaulted her mother. So much for communication.

On a positive note, my daughter has regained her driver's licence. She's talking to her mother again and

trying to get back on speaking terms with her brothers, but that could change—that could change tomorrow. Life is one day at a time, never be too optimistic and always expect the worst. That's the family perspective on mental illness.

I'd now like to ask Earla to present the consumer's perspective.

Ms. Earla Dunbar: Thank you, Dennis. Hello. I'm very happy to be here but very nervous. My name is Earla Dunbar and I am presenting as a consumer-survivor.

At the age of 44 in 1998, I finally found help for my social phobia, agoraphobia, panic disorder and depression. When I was five, I started to feel different, not wanting to leave the house without a family member, feeling sick and not going to school.

Then, when my father died when I was nine, the depression set in. The psychiatrist I was seeing at the time told my mother to take me to the Penetanguishene mental hospital and said that if I did not straighten up, this was where I would end up. The hospital terrified me, and from that day forward I became a happy little girl. Then the other disorders set in.

In the years following, I became agoraphobic, depressed and socially anxious, and the panic seemed to be with me all the time. Then I began to disassociate. There were many suicide attempts during all this time.

When I finally got help at the Centre for Addiction and Mental Health, I was relieved but terrified to tell my family since there was so much stigma about mental health. When I finally told my mother, she took me out of her will and would not talk to me for awhile. She blamed me for putting the family to shame. Only when I started being interviewed on TV and in the media, and her friends found out and thought it was so brave of me, did she accept me back as her daughter.

Because of my disorders, I could not even finish grade 10, and in my work, never was able to get further in my workplace. People thought I was stupid and/or a snob. My terror of everything and everyone put me in a shell, a terrifying, scary and very dark place.

If we could reach out to all children, what a wonderful chance they would have to be able to continue in school, make friends, join in family gatherings, work at what they want, grow and have a life, instead of hiding, which is what I did.

I am the founder of the Social Phobia Support Group of Toronto. When I talk to them, I say, "It is up to you to talk about your mental illness. If you do not, who will?" But so many feel embarrassed by their illness.

Social phobia is the third-largest mental health illness we have, yet there are so many still suffering. We must speak up and tell people not to be ashamed and that they can get well.

I feel very fortunate that I do have my life back and that I've had such wonderful support with professionals and still do. Also, what is so refreshing is that I am not terrified of people. I am now making friends. I never

thought I would be where I am in this world today, and I'm so glad I'm still here.

These are my recommendations and the support for them.

To be successful in helping others, early intervention is necessary. Education in mental health to parents, teachers, family doctors and young adults is needed. Every person who is part of a school community is a teacher for mental health and well-being.

One out of four young adults will experience a mental disorder within a 12-month period. Early recognition and treatment reduces long-term treatment. As young adults, they feel powerless, guilty and utterly alone.

Thank you for your time.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Earla. Thank you, Dennis. You've left time probably for one question, perhaps two. Starting on this side, any questions? No? Christine? Sylvia?

Ms. Sylvia Jones: I just wanted to thank you for bringing the presentation forward. You are not the first family member or supporter who has talked about the need to change the privacy issues. I appreciate you bringing your personal story, and thank you for sharing. I'm glad that it has worked better because of the supports you were able to get. I'm just disappointed that it took as long as it did.

The Chair (Mr. Kevin Daniel Flynn): France?

M^{me} France Gélinas: I took in all the anger you had towards the health care system. It's certainly justified, with what happened to your family.

You made a recommendation that "The College of Physicians and Surgeons and the College of Nurses should issue guidelines"—I'm reading what you said—"for dealing with the mentally ill patient and deviations from these guidelines should be reportable and subject to discipline." I'm really surprised that it is not. I mean, they all have codes of ethics, don't they? You said you were a physician. I take it that it's more of a culture that people don't report when one of their members actually displays the behaviour that you've given as an example?

1710

Dr. Dennis Reid: When you work in the acute care situation in the hospital and if a mentally ill patient comes in, it's quite amazing the type of stigma they're subjected to by professionals. I'm not talking about porters and other staff, but physicians and nurses.

No, it is not reportable. There are no guidelines on how to deal with it. The mentally ill are treated, really, quite badly when they go to the emergency department, particularly if they're triaged through the regular system. If they're triaged through a mental health triage system, then very often they can bypass the major triage systems where all the heart attacks and other patients go. But by and large, they are triaged through the regular system and left to lie on a gurney for several hours. They may be screaming and yelling. My own daughter was told, "We're not going to talk to you unless you behave yourself." Well, when your brain's malfunctioning, it's different from your heart malfunctioning.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Dennis, and thank you, Earla, for coming forward. It really is appreciated.

ONTARIO ASSOCIATION FOR SUICIDE PREVENTION

The Chair (Mr. Kevin Daniel Flynn): Our next presenter—this is going to come down to a very tight thing, here. We've got the Ontario Association for Suicide Prevention. All the members are going to have to leave for a vote in about 15 minutes, so just so you don't take it personally, if we hear from you and sprint out of the room, it's nothing you said.

You were here for the rules, so why don't I just let you go. Walter Mulkewich told me you were coming.

Ms. Rahel Eynan: Chairman, members of the committee, thank you for the opportunity to appear in front of you and to discuss the tragic public health issue of suicide and the urgent, challenging questions associated with its prevention.

To those not suffering from depression or another mental illness, suicide fundamentally is an inconceivable act, but for others, it is all too real—

The Chair (Mr. Kevin Daniel Flynn): I'm sorry, I should have asked you to introduce yourselves.

Ms. Rahel Eynan: Okay. I'll go back. My name is Rahel Eynan. I'm the president of the Ontario Association for Suicide Prevention. This is my board member Wayne Hobbs.

I'll continue the sentence.

The Chair (Mr. Kevin Daniel Flynn): I didn't mean to disturb you, but we had to get that in for Hansard.

Ms. Rahel Eynan: Okay. No problem—but for others, it is all too real, and it claims the lives of nearly 4,000 Canadians each year, people of every age, both men and women, within every group of our population regardless of socio-economic status. In fact, in Canada, more people die by suicide than motor vehicle accidents; more people die by suicide than by homicide and HIV combined. The suicide rate is nearly 11 per 100,000, which exceeds those of homicide, which is 1.9 per 100,000, and HIV, which is 1.3 per 100,000.

In Ontario, suicide is one of the leading causes of death—it's actually number 10. In 2005, 1,115 people died by suicide, so each day, three people killed themselves. The number of suicides increased from the year 2000 to 2005 by 21%, and there are as many as 20 attempts for every suicide. From April 1, 2001, to March 31, 2002, there were over 24,000 ER presentations for self-harm.

In 1999, there was a report written to the Ministry of Health and Long-Term Care and the Ministry of Health Promotion that indicated there were 83,000 self-inflicted injuries. Of those, over 9,000 were hospitalized and 73,000 were non-hospitalized injuries. The same report assessed the cost to our economy, and the cost of suicide and self-harm, in direct and indirect costs, was \$886 million. Ninety per cent of the people who kill them-

selves have depression or another diagnosable mental or substance abuse disorder, so suicide is a major public health issue.

Now I'll let my colleague continue.

Mr. Wayne Hobbs: Thank you for the opportunity. I commend the committee for tackling this very complex issue. The number of presenters before us and the variety of topics just underlines how widespread this issue is and how it touches every part of our society.

Just for my background: I've worked in school boards for over 30 years in London, Waterloo, now Grand Erie. I'm on the board of Parents for Children's Mental Health and the first presenters on Health-Connect. I'm on the board of K-W Counselling Services and the Ontario Suicide Prevention Network, so I've got a bit of perspective to bring to this topic.

Certainly, our previous presenter talked about attitudes and stigma that continue to exist, and they exist within the health care system. I think that the Honourable Maria Van Bommel from London area knows the old Victoria Hospital. I was in there years ago getting stitched up after a hockey incident and the emerg room there was not divided; it was just curtains that would be drawn around individual beds so you could hear everything that was going on. The doctor stitching me up stopped in mid-stroke because of a commotion in the bed next to me. A young man had tried to harm himself and came into the hospital and the hospital staff were yelling at him for taking up their valuable time. That kind of attitude continues and it results in inequitable access to service for people with mental illness and addictions.

But we know from science that suicide is preventable. There are a lot of beliefs out there that this is fate, that it's inevitable and don't waste your time trying to help people who want to harm themselves, and that couldn't be further from the truth.

One of the other areas, though, that I'd like to talk to you about is the lack of coordination of policies and services. On your second page—as I said, I work in a school board, and over the last six months to 10 months this is an example of the number of policy statements that I have coming to me. It started with the Mental Health Commission of Canada and then this July with the release of Every Door is the Right Door. When I went to a meeting chaired by somebody from the Ministry of Children and Youth Services, they were unaware of the Every Door is the Right Door policy statement. Minister Wynne has talked about mental health being a priority in school systems. There are so many competing messages that come to service providers, and I'm sure that you've heard many times before about the importance of coordinating initiatives and collaborating instead of competing, as it takes a lot of our valuable time.

Ms. Rahel Eynan: Other provinces in Canada have initiatives and strategies for suicide prevention: Prince Edward Island, Newfoundland and Labrador, Nova Scotia, New Brunswick, Quebec, Manitoba, Alberta, Saskatchewan, British Columbia is just issuing their strategy at the end of the month, Nunavut, Yukon and the

Northwest Territories. Ontario doesn't have a suicide prevention strategy as yet. In Ontario we do have, however, an endowed Chair in Suicide Studies at St. Michael's Hospital, which is part of the University of Toronto, and the Ontario Association for Suicide Prevention is working on developing a provincial suicide prevention strategy.

So what are our recommendations? We need to establish an interministerial leadership body for suicide prevention and mental illness and substance abuse and addiction. We need to establish a mental health and addictions strategy that encompasses a comprehensive suicide prevention strategy. It also requires interministerial collaboration and coordination. For example, we cannot have screening of children in schools without involving the Ministry of Education. So if we have a true strategy of reducing suicide, we have to work with other ministries beyond the Ministry of Health and Long-Term Care.

To save lives in Ontario we need a provincial strategy for suicide prevention, a strategy that will promote awareness that suicide is a public health problem that is preventable. We need to develop and implement strategies to reduce stigmas that are associated with being a consumer of mental health, substance abuse and suicide prevention services.

Just to go back to what Wayne and the presenter before said regarding stigma in hospitals by professionals, one of the terms that is used in hospitals for individuals who repeatedly attempt suicide and frequently come to the hospital is "frequent flyers," which really debases their distress and suffering. It's a term that's used. I work in a hospital and I'm aware of it.

We need to promote the implementation of community-based suicide prevention programs that ensure early identification and effective intervention. We need to have screening of school children, in high schools and universities, but hand-in-hand with that, we also have to have services to which they are going to be referred if we discover that they are depressed, bipolar or they need any other help.

We need to improve the access to community linkages with mental health and substance abuse services. We need more detox centres, we need physicians, we need therapists; we need to support the fees that individuals have to pay for services that are not covered by OHIP.

We have to promote efforts to reduce access to lethal means and methods of self-harm. Twenty per cent of the people who kill themselves kill themselves with firearms. The other high number is self-poisoning with medication. We need medications that are lethal in large quantities which are given for depression to be dispensed in a different way so that it will limit the number of prescriptions that individuals have access to. We also need a registry where people cannot get medications from different pharmacies, but the pharmacies are all co-ordinated so they cannot shop all around in order to get medication, hoard medication and then take it.

We need to promote and support research on suicide and suicide prevention, so we need dedicated funds that

go to suicide research. We also need to be able to evaluate the programs that are implemented when they are implemented.

We need to improve the reporting and portrayal of suicidal behaviour, mental illness and substance abuse in our entertainment and news media. It must not be sensationalized. It has to be factual reporting and must also include a crisis line number when it's reported.

We need to improve and expand our surveillance system. We really don't know how many suicides there are. We are talking about 4,000, but all of us in the field know there are many more incidents that are undetermined or are suspicious deaths that most likely are suicides. We need to develop protocols for our coroners that will accurately determine the cause of death. Also, we need to have protocols for collecting information on non-fatal attempts and we need to standardize those protocols all across the province.

That's our presentation. Again, thank you very much for giving us the opportunity to discuss it. If we can be of any assistance to this committee in any way, we'll gladly do that.

The Chair (Mr. Kevin Daniel Flynn): Thank you. We're really glad you came today. We probably have time for one quick question. Christine or Sylvia, do you have anything?

Mrs. Christine Elliott: I just wanted to say thank you very much for putting the time and thought into this paper and for appearing in front of us today. There are a lot of things that I'd like to have time to address, but unfortunately, I don't. I did just want to assure you that we are aware of the need to coordinate programs with all of the various ministries because we know that it's not just the Ministry of Health and Long-Term Care; it goes across virtually every government ministry, so point well taken. Thank you.

Ms. Rahel Eynan: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming.

We're recessed for about 10 minutes, so members of the audience, that means that members of the committee will go up to the House, we'll vote, and we should be back here in 10 minutes.

The committee recessed from 1722 to 1732.

NORTHUMBERLAND POVERTY REDUCTION ACTION COMMITTEE

The Chair (Mr. Kevin Daniel Flynn): Okay, if we can come back from recess, then. Our next presenter is Lois Cromarty, chair of the Northumberland Poverty Reduction Action Committee. Have a seat, Lois. Make yourself comfortable. Thanks for waiting.

Ms. Lois Cromarty: Great. No problem.

The Chair (Mr. Kevin Daniel Flynn): Like everybody else before you, you get 15 minutes. Use that any way you see fit. If there's time at the end for any questions, we'll try to split it amongst everybody here.

Ms. Lois Cromarty: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Let me get my theme going.

Interjection.

The Chair (Mr. Kevin Daniel Flynn): There may be another vote coming in half an hour. That may make it a little problematic, but let's give it a try.

Ms. Lois Cromarty: Thank you for allowing me time to speak today. I am a lawyer and I'm the executive director of the Northumberland Community Legal Centre, out in the county of Northumberland, in Cobourg.

I'm presenting to you today in my capacity as chair of the Northumberland Poverty Reduction Action Committee. Part of our mandate, as a broad-based coalition, is to try to shine the light of poverty reduction action on different agendas. The members of our committee are—we're quite broad-based. We include everything from the faith community to the county of Northumberland itself, the United Way, labour and education.

We're quite broad-based, but we're all with that focus of trying to take action to reduce poverty and to get that on every agenda, which is really why we're here today, because as you know, poverty and mental illness are very closely linked.

Lack of health care is also tied to poverty and to mental illness. Because health care falls into one of our poverty reduction action areas within the county of Northumberland, we wanted to be sure that poverty reduction forms a part of any mental health and addiction strategy that is to be put in place.

So I'm here today to deal with not only the low-income aspect of mental health and addiction but also the rural nature, and the problems facing rural residents who have mental health and addictions issues.

I'm not a mental health expert. I did some research and found that there are huge numbers of reports on mental illness and what the mental illness strategy should be in this province. I think 20 were issued within the last 25 years, as listed by the Canadian Mental Health Association, all endorsing the principle that services should be moved from institutions into the communities.

Other studies out there that you may not be aware of—one in particular, dealing with the relationship between mental illness and poverty, is one done by Dr. Gina Browne, a researcher with McMaster University, who did a study for Hamilton, Wentworth and Halton regions called *When the Bough Breaks*. Her study dealt with whether you could influence the length of stay on social assistance by providing things like mental health supports to social assistance recipients. In her study on the prevalence of mental health issues amongst social assistance recipients, she found that in that region—Hamilton-Wentworth-Halton—60.4% of social assistance clients had two or more mental health problems.

Her study also went on to prove, or show, that if you gave full intervention services—that is, if you gave that client base of sole-support parents employment services; in-home visits by a public health nurse who was dealing with mental health issues; quality child care and recreation; income; pharmacotherapy and counselling—25% of

sole-support parents would exit the social assistance system within one year, versus 10% if you did nothing for them, quite a significant difference. The investment upfront in those types of services to social assistance clients with mental health issues—there's quite a savings when those people leave the system.

1740

There's also a big tie-in between homelessness and poverty and mental illness. The Kirby report certainly found a rather tragic relationship between homelessness and mental illness. There's quite a link between mental illness and abused women. The local statistic from our women's shelter is that 80% of their clients have mental health problems. In the health care sector, there's no question that those with serious mental illness have greater difficulty in getting general health care services and they, in turn, receive a poorer quality of care compared to those without a mental illness. That has been studied as well, both in the United States and in Canada.

What's probably not too apparent in the studies is the on-the-ground effect on those with mental illness or addiction issues. The funding turf war between programs—it's health versus some other agency—means that there's a lack of treatment for people with dual diagnoses; that is, with both a mental illness and a concurrent disorder. Certainly those studies don't give you the full flavour of the disproportionate effect that mental illness has on low-income people, that those mental health issues and addiction issues, if they're left untreated, can lead to and leave you in poverty.

There's certainly a lack of sensitivity amongst the service providers in public programs. I see that in my work as a lawyer with the legal clinic, that clients with mental health issues or addiction issues are often seen as non-compliant and they consequently lose their income. They put their housing at risk. If they're in social housing, they face a greater chance of eviction.

The way the social assistance rules are written, if you're hospitalized for more than three months, you're going to lose your income and you are going to lose your housing. You're even further behind the eight ball when you come out of hospitalization.

From a rural perspective, that are lots of barriers that discourage individuals from even accessing the services that are there. Transportation is a big issue, or lack thereof. There are studies that show that the hub model of providing services in hubs has no reach beyond about 10 kilometres, that if you pass that distance, you're not going to go to those services, and that's a big barrier in a rural community like our own.

Funds: For a low-income person, it doesn't matter what the fee is for a service; if it's not covered by OHIP and you have to pay for the service, a fee for service will cut out that portion of the population regardless of the size of the fee. There are obviously long wait lists in the "free" services.

The poverty reduction action committee wanted you to hear a bit about what we see on the ground in North-

umberland county. We're a rural county. We're about 70 miles east of here. What we've seen and what our day-to-day circumstances are for those with mental health issues and addiction issues are: There are no crisis beds in our county. The crisis beds are in neighbouring counties, in Oshawa, Peterborough or Belleville. So if you're a low-income person with a crisis issue, you're going to have to travel and your family is going to have to travel to get to you—70 kilometres or more if you live in Cobourg.

There are no methadone clinics in our county. Again, if you're taking daily methadone treatment, you either have to go to Belleville, Peterborough or Oshawa to get that service—a huge consideration in terms of the cost of travel for low-income residents.

There are no supportive housing units in our county for those with a dual or a concurrent disorder—that is, a mental health and an addiction issue. The few units of supportive housing that we do have are only for what I would call a select group of mental health problems. They don't take clients with mental health disorders that aren't on their particular list.

There's no supportive housing in our county for those with addiction issues. There are no residential treatment programs in our county. Our local community counselling centre that was started and funded by the United Way needs ongoing operational funding and has a wait list of clients who are waiting to use those services. We definitely have a shortage of mental health professionals, and the one wellness centre that we have in our county accesses psychiatrists by videoconference, which is not an appropriate service for lots of different types of mental illnesses. For myself, I couldn't imagine sitting in a room by myself looking at a camera trying to describe my mental health issues by Skype to somebody who's sitting somewhere else out of my view in a different town.

One of the other large problems that we have in our county are the decisions of the LHIN, the local health integration network. We're in a LHIN that starts at Scarborough and ends at our border, so when you talk about where the resources are going to go, if you're including Scarborough, Pickering, Ajax, Whitby, Oshawa, Peterborough and us, we're way down on the list of where those resources are going to go. In fact, some of the LHIN decisions directly impacted us. When the decision was made by the LHIN to distribute \$16 million worth of supportive housing in the central east LHIN, they decided that they were going to place those in blocks of eight units. Scarborough got the largest chunk of blocks of eight and it funnelled down to the last block of eight, which got to Peterborough. That was all that was left—none for Northumberland county.

One of the other things that I wanted to bring to your attention is the form 1 process, when someone is brought in as a danger to themselves or others. We have two hospitals in our county. That form 1 process bears extensive costs not only for the community but for the individual themselves, especially the low-income individual. If you're brought in on a form 1 to the local hospital in Cobourg, you have two police officers who stay in the

emergency room with you. In a small police force, that's a big investment of resources. You're stripped of your belongings, and if you're a homeless person and you've only got your ID, everything you have is on you. When you're stripped of that, that's placed in somebody else's care and custody. Then you're transported out of Northumberland county to Peterborough. In that ambulance ride, you're accompanied by a registered nurse—again, another health care cost. But your belongings may or may not go with you, and may or may not come back with you when you're discharged from Peterborough. I don't have to tell you what the loss of identification documents means. Everything in our lives depends on that. Health care depends on that. Accessing social assistance depends on that, so when you lose your birth certificate, your driver's licence, anything that identifies you as you, it's very hard in our society, in the system as it is today, to get those things back and to get back on track, get your identity back.

It doesn't also factor in travel costs. If you're a form 1, as I say, in Peterborough and you're housed there in Peterborough and you live in Northumberland county there are costs for your family to come and see you; there are those costs of the health care provider who goes up and has to wait in Peterborough until you're admitted; there's the cost of the police officers, as I say, to remain in the ER while you're awaiting transport. But the other costs that are sort of hidden are: When you are released on a form 1, there really aren't any local services to help you when you come back to Northumberland county, so we lose people. There's a lack of repatriation because you've got nothing to support you when you do come back to our community.

The poverty reduction action committee has asked me to make the following recommendations to you when you're drafting any sort of provincial mental health or addictions strategy. We urge you to put poverty reduction measures in the strategy and to ensure that the strategy addresses low-income concerns. The strategy should supply supports to low-income residents in accessing service—should cover travel costs, child care, that sort of thing. We want the strategy to address the rules and policies in both social assistance and social housing that put your housing or your income at risk for those with mental illness or addiction issues. I'm not just talking about the hospitalization; I'm talking about the compliance issue as well. We want you to look at eliminating those barriers to accessing service and to provide supports in the strategy to municipalities if you want to create that full intervention method, as Dr. Gina Browne showed was so effective in Hamilton-Wentworth-Halton.

1750

The strategy should also address the concerns of a rural population. We have 88,000 people who live in Northumberland county. We want you to deal with transportation costs and focus on creating locally-based services, because studies have shown that a satellite method is not as effective as place-based service for clients.

The Chair (Mr. Kevin Daniel Flynn): Just so you know, Lois, you have about a minute to summarize.

Ms. Lois Cromarty: Yes, okay.

The Chair (Mr. Kevin Daniel Flynn): Thanks.

Ms. Lois Cromarty: Lastly, we want you to integrate mental health and addiction strategies with the other strategies that are at play at the moment: the poverty reduction strategy, the affordable housing strategy. Nothing should be considered a stand-alone strategy, because mental health cuts across all of those sectors.

I'll leave you with the rest of my list of recommendations from the Northumberland Poverty Reduction Action Committee. We certainly hope that in the development of any strategy, you look at what is the impact on the low-income and the rural person in accessing those services.

Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Lois. I was reading ahead a little bit, and you've done a very good job of summarizing the recommendations for the members. Just because you didn't go over them, don't think that they won't be paid attention to.

Thank you very much for your time today, and thank you for appearing before the committee.

Ms. Lois Cromarty: Thank you.

WATERFORD FAMILY COUNCIL

The Chair (Mr. Kevin Daniel Flynn): Don, this leaves me with a little bit of a challenge. We could either not start you for about half an hour, or we could start you and stop and go and vote and come back and do whatever time you have left after that. It's entirely up to you. I wish we weren't in this position, but we are. It would be unfair to you for you not to make the call.

We're going to have to go and vote in about 10 minutes. We could hear the first 10 minutes and we could come back for the summary.

Mr. Michael Leaker: Okay. We can do that.

The Chair (Mr. Kevin Daniel Flynn): Okay. You can all come forward, if you'd like, to give him some moral support here.

Mrs. Christine Elliott: Chair, is there a written presentation?

The Chair (Mr. Kevin Daniel Flynn): Is there any written presentation or is everything just oral?

Mr. Michael Leaker: Everything's just oral.

The Chair (Mr. Kevin Daniel Flynn): Okay, super. If you'd identify yourself—I know Don, but if you'd identify yourself for Hansard, we'll take it from there.

Mr. Michael Leaker: My name is Michael Leaker, and this is Don Moffat. We are here on behalf of the Waterford Family Council. First of all, I'd like to thank you for inviting us to address your committee.

The Waterford Family Council is a group of concerned people whose family members reside at the Waterford long-term-care facility in Oakville, Ontario. Our purpose is to help other families whose loved ones have moved into the home, to make living at the long-

term-care home a better experience for our loved ones, and to become their advocates as they lose the ability to advocate for themselves.

Many of our loved ones have moved into a long-term-care facility because they are no longer able to take care of themselves, or their families are no longer able to take care of them.

Before coming here, I was talking to a few of the doctors who tend to the residents in the long-term-care homes throughout Halton, and also to the Halton Geriatric Outreach Program. They estimate that just over 80% of their patients are on some form of antidepressant or antipsychotic medication. That is why I am really glad to be here today to address you.

Some of our loved ones were on these medications before they moved into these facilities. My mother-in-law lived with me for a number of years before she developed a severe case of clinical depression and anxiety. She had suffered bouts of depression for decades. The biggest hurdle we had this last time was the fact that she was over the age of 65. The mandates of organizations such as CAMH, many outpatient services, community services and experimental therapies do not include those who are over the age of 65 and thus were unavailable to us.

In cases where we have elderly spouses trying to care for their elderly loved ones, the spouse needing the care can receive some help through the CCAC; however, the elderly caregivers themselves are not eligible. We see cases where one person's laundry is being done and not the other's. Only one person's bed is being made; only one person is receiving meals. While this does help the caregiver a bit, the caregiver could use some support themselves.

The wear and tear on the caregiver sometimes results in both individuals moving into a long-term-care facility. When the families have compared the costs of assisting a person to stay at home to living in a long-term-care home, they discover that it would have been less expensive to the province as a whole to have increased the amount of in-home care. Also, hopefully the couple ends up in the same facility. It is not uncommon for them to end up in different facilities, and that brings about its own type of mental anguish for them.

In terms of getting community support and applying to move to a long-term-care home, the CCAC has been a consistent source of disappointment for us. Fundamentally, we believe that they are understaffed. I once called their 24-hour helpline, and my call was returned two weeks later. In the meantime, my mother-in-law was admitted to hospital. Another family member from our council ended up going directly to their offices in the hopes of getting hold of someone.

Part of the purpose of the long-term-care homes was to bring together people with similar backgrounds, life experiences and conditions in the hopes you could help them cope and become better. However, we are also now seeing a more broad spectrum of individuals moving into the homes. We have one individual, a 26-year-old, who's

a quadriplegic. We've had wheelchair-bound autistic teenagers stay at the home for respite care. There is a growing number of individuals in their early 50s suffering from alcoholic dementia moving in as well.

Some of these individuals I just described do not have the same life experiences as those who live there normally. I imagine it is also quite shocking for some of them to find themselves living in a long-term-care home filled with seniors. It also makes some of us worry that the long-term-care facilities are being used to house those that we, as a province, do not know what to do with, turning the homes into the institutions of old, the ones that we have closed.

Also, some of these individuals are quite demanding in terms of needing assistance. We feel that the ratio of personal care providers to residents is too low to begin with. They do not have the time to help everyone get up in the morning, eat their meal and go to the washroom after a meal in a timely manner. For example, the workers have about 10 minutes per person to wake them, dress them and have them ready for breakfast in the morning. I know it takes me longer to do that. A number of us have hired outside help to assist with feeding our loved ones. Some of us have also hired caregivers to assist them with getting up in the morning, allowing them, say, half an hour to get ready, and taking them to the washrooms after meals while they are still living in a long-term-care home.

Personally, my wife and I are in the latter group. We hire five individuals for a total of 42 hours a week to assist my mother-in-law, and it has made a great difference. A number of other council members average about 10 to 16 hours a week in additional care, mainly to help with eating. Given that people are living longer and the province is behind in building long-term-care facilities, space is already at a premium, and we are worried about the effects of expanding the mandate to include other people who do not share the same life experiences as many of the seniors we have.

Also, there's an increased number of individuals coming into homes with severe behavioural problems or mental health issues: Alzheimer's, dementia, depression, schizophrenia and others. This is in addition to the individuals who develop Alzheimer's, dementia and depression after moving in. We are finding that the staff in these homes, while equipped to deal with some of the simpler forms of dementia and Alzheimer's, are not equipped to deal with all the mental health issues that are coming in.

At the Waterford, it seemed that when my mother-in-law moved in, she was the first person they had really encountered with severe depression and anxiety. Many of the staff asked us if they'd be receiving any training in how to deal with someone with severe depression. None came. The geriatric outreach program has been asked to examine a number of people's medications in long-term-care homes, only to find that those individuals only needed more socialization, more human interaction, and were given anti-psychotic medications to calm them

down instead. The impression many of the family members have is that drugs are used to sedate residents so they are easier to care for.

Seniors present health care providers with complex medical, functional and psychological problems. It's not an easy thing. This creates difficulties in obtaining proper diagnoses. Improper diagnosis can lead to premature loss of health, independence, well-being, and increased time in the hospitals.

In the Halton, Hamilton and Brant area, there are a total of 20 beds to deal with individuals with severe behavioural and mental health problems; 10 of those beds are usually taken up by individuals waiting for some place to move to. That leaves 10 beds to circulate the patients through. To handle just the senior population that resides in Halton region who could use these facilities, the doctors in the geriatric outreach program in Halton would actually like to have a 20-bed unit for every three to four long-term-care homes. That would be a few units within the region, not just one for many.

The Chair (Mr. Kevin Daniel Flynn): Michael, you've got about two minutes left, so you choose the appropriate time when you want to end the first part of your presentation.

Mr. Michael Leaker: Actually, I think I might be able to finish it off, and you can come back for questions.

The Chair (Mr. Kevin Daniel Flynn): Okay, perfect.

Mr. Michael Leaker: I don't want to leave you with the impression that there is nothing out there. The Seneca program in Oakville is wonderful. It has a long waiting list and is great for seniors with mild cognitive problems. Caregivers who have used the VON Alzheimer's program cannot say enough about how great that program is. Sadly, the programs available to seniors are limited, and we wish there were far more available.

In closing, we'd like to see more programs available to seniors, like CAMH, even if it's just available for residents of Ontario. We would like to see the personal care providers at the long-term-care home be better prepared to take care of residents with mental health issues and we'd like to have more of them so our seniors can receive what we consider an adequate level of care. We get the feeling that seniors are neglected by our society, and that's a shame because they helped build it. I hope that as you consider changes to the care seniors receive for mental health and addiction, you consider what sort of care you would also like to see when you reach your golden years.

The Chair (Mr. Kevin Daniel Flynn): That's wonderful, Michael. Thank you. A good spot to end; when we come back, we'll go straight to questions.

We're recessed.

The committee recessed from 1759 to 1808.

The Chair (Mr. Kevin Daniel Flynn): If we can reconvene. Thank you very much for the presentation, Michael. You've left quite a bit of time for questions. I think it was either France or the government side that was going to start, so why don't you start, France?

M^{me} France Gélinas: Actually, I was quite surprised by what you were saying about the amount of extra help

you had to bring for your mother-in-law in the long-term-care home. Do you figure that this extra help is needed specifically because she has a mental illness, or is it throughout this home that basically the regular staff can't cope and people end up having to hire their own?

Mr. Michael Leaker: I believe it's throughout the home and it's not just this home, to be honest. It also occurs in other homes; a lot of people supplement the care.

Mr. Don Moffat: A lot of people in the home have dementia and/or Alzheimer's. There are three personal support workers for every 29 people in the home area. When you're talking about trying to feed those people—my mother has severe Alzheimer's. It takes 45 minutes to feed her on a good day. How does the math work? It doesn't. That's why you pull out your wallet and pay.

M^{me} France Gélinas: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Anyone from the government side have a question? No. Sylvia?

Ms. Sylvia Jones: Thank you for coming. You've raised a few issues that I was not familiar with. I'm not sure if it was Don who talked about the—

Mr. Don Moffat: Michael.

Ms. Sylvia Jones: —Michael who talked about how after your mother-in-law reached 65, there were no avenues of support for her mental health issues?

Mr. Michael Leaker: Unless we admitted her to the hospital, yes.

Ms. Sylvia Jones: So anything that you were getting from community mental health, any of that, it just outright stops? What was the process? How did that happen?

Mr. Michael Leaker: I called up CAMH for help and I was told, "Oh, I'm sorry, but your mother-in-law is over 65. We cannot help you. It's outside of our mandate."

Ms. Sylvia Jones: And was she receiving help prior to 65?

Mr. Michael Leaker: She didn't need it—oh, sorry. When she was younger than 65?

Ms. Sylvia Jones: Yes.

Mr. Michael Leaker: Yes, she had received some help, but she really didn't need it. Her case was that she might suffer from depression for six or seven months, some medications would resolve the issue, she'd be fine for five to seven years, then suddenly the medications would stop working. One time, she had to take ECT or electroshock therapy. It worked wonders the first time. Last time, it was ineffective.

Ms. Sylvia Jones: Okay. You also raised your frustration with the community care access centre.

Mr. Michael Leaker: Yes.

Ms. Sylvia Jones: Are you receiving any assistance from them as they provide service within the long-term-care facility?

Mr. Michael Leaker: I wasn't aware they could provide services within a long-term-care facility.

Ms. Sylvia Jones: So they're not doing any at all?

Mr. Michael Leaker: No.

Ms. Sylvia Jones: Okay. Thank you.

Mr. Michael Leaker: That was in their mandate?

Mr. Don Moffat: No.

Ms. Sylvia Jones: Just one point of clarification: You hire 42 hours a week?

Mr. Michael Leaker: Forty-two hours a week: six hours a day, seven days a week.

Mr. Don Moffat: And my family probably hires 20 hours a week.

Ms. Sylvia Jones: In a regulated—

Mr. Don Moffat: Government—

Mr. Michael Leaker: Publicly funded, privately run, for-profit long-term-care home.

Ms. Sylvia Jones: They all have the same rules. Thank you.

The Chair (Mr. Kevin Daniel Flynn): I have a question. I was talking to some of the senior staff down at Oakville Trafalgar Memorial Hospital, and they were saying how often somebody will exhibit behavioural problems that are the result of some mental health issues and will end up, because of the inability of the staff at the home to deal with that, at the hospital. The home will then, when they have been triaged at the hospital and it's time to send them back to the home, often say, "We aren't equipped to deal with this person," and the poor person is caught between the hospital and the long-term-care facility that used to be their home. Have you seen examples of that at the Waterford?

Mr. Michael Leaker: I have not. Have you?

Mr. Don Moffat: No. I've seen a lot of people go to the hospital that possibly—if they checked for urinary tract infections on a regular basis, that would probably stop a lot of people from exhibiting signs of dementia and things like that. Being proactive rather than reactive would probably help out a lot. When you've got people in long-term care, it seems that they treat reactively and not proactively.

The Chair (Mr. Kevin Daniel Flynn): Okay, thank you. Any other questions? We've got time for one more.

Thank you very much for coming today. We certainly appreciate you taking the time out of your day to do that.

Mr. Michael Leaker: Thank you.

RANDI FINE

The Chair (Mr. Kevin Daniel Flynn): Our final presenter of the day is Randi Fine. Come forward and make yourself comfortable. Like everybody else, you have 15 minutes. Use that any way you see fit. If there's any time left over, we'll split it just like we did then.

Ms. Randi Fine: We'll try.

The Chair (Mr. Kevin Daniel Flynn): Very good. It's all yours.

Ms. Randi Fine: Okay. Thank you so much for seeing me as a person. I could have come here with many different titles and many different hats, or my one big hat, as I like to say, but I chose to come here as someone who has been affected by mental illness in my own life at every stage.

I'm here as a daughter of a father who was bipolar for over 50 years; as a sister—two sisters: one who suffers from bipolar disorder and one who suffers from an anxiety disorder; as a mother of a daughter who had childhood depression but has done unbelievably well; and then there's me. I fight my own demons, but some of them I have chosen to fight as an advocate for seniors' mental health services. I want to tell you a little about my own journey and how I got there.

Many years ago, I found great interest and delight in working with seniors. I've had the privilege of doing so for many years and hope I always will, and I've always been an advocate for seniors. As my dad grew older, and so did those I was working with, I began to wonder what was being done about seniors' mental health. I found that, in fact, there was very little being done.

Sitting here today, I learned a few things and heard much of the things I've heard before, but it's fascinating that we're all here because, until a few years ago, none of us were talking about seniors' mental health.

During this time, specific incidents piqued my interest and concern. My dad's heart attack made me realize something had to be done. Let me tell you a little about that.

My dad had been hospitalized at the time in a very well-recognized psychogeriatric unit for almost three years—one of many long hospitalizations—and he was so seriously depressed that he was constantly and actively suicidal and totally withdrawn.

One night, he complained of terrible pain in his stomach, which was very unusual because he barely spoke to anyone at that time. Sadly, the staff dismissed his pain and offered him orange juice. In fact, it turned out he was in the middle of a serious heart attack, which, by the way, presented as stomach pain because he was diabetic—something I've learned. It was not discovered until the next morning that he had had this serious heart attack, when he was found in a coma.

Luckily, with lots of adventures in between, he did come back to us. Though we were told that he had two weeks to live, he was very stubborn and he managed to live for 18 more months. What was really fascinating was that, with this heart attack, his depression finally lifted for the first time in many, many years, and so he had a wonderful last 18 months.

But what I want to emphasize here is that because he was on a psychiatric unit, his physical symptoms were not taken seriously. One important lesson is that older adults are complex folks, and those with mental illness often have medical problems and vice versa. So we can't think of older adults with mental illness as just people with mental illness who age; there are both issues to consider.

1820

Around that time, while all this was going on, I had the opportunity to focus on seniors' mental health and began networking with contacts across the sectors. I'd been around for a long time so I had lots of contacts. Eventually, I was able to form, with many other people,

an organization called the Older Persons' Mental Health and Addictions Network of Ontario, which brought together people from across the sectors of seniors' mental health and aging and which made great strides in bringing together older adults and people who had never been involved in this conversation before. It managed to survive as an organization until 2008, when we couldn't achieve sustainability, which is, indeed, very sad. So there is, in fact, no network that cuts across the issues of seniors and mental health in this province.

Since then I've been out advocating, sitting on committees and boards and doing my favourite thing, which is training with seniors, caregivers and staff. Let me assure you that seniors do want to talk about mental illness. I'm often asked to speak both for seniors' groups and for staff. They're hungry for information, but I'm limited in what I can do as a volunteer, and they have no funding to buy education, so there is a huge gap.

I want to put before you certain conclusions and recommendations that are probably no different than any you've heard before. I've heard some of my colleagues today; I've read most of the submissions you've had from the various seniors' organizations, but I'm here with my passion and with no title because I really want these to be my recommendations, because I have often been accused of being too passionate, so now I have my chance. Here are my thoughts.

Seniors' mental health must be a priority not only because of the demographics and costs but because it's the right thing to do. I have been in this business for a long time—I'm getting to be able to say that myself—and we have been talking about these issues for the last 40 years. It's time to stop talking and start doing. We all know what's coming in terms of the growing seniors' boom. We know that with more seniors there will be more mental illness. We will have a crisis. It is time to do something now.

We need to be talking about various groups of seniors when we're talking about mental illness. We need to consider the needs of those people who are growing older with mental illness as well as those with age-onset mental illness, which includes dementia. Dementia itself is devastating and important to address but seniors' mental health is much broader. Often, when we are talking about seniors' mental health we're talking about dementia, and that's really very limiting. In fact, until seniors reach 80, depression is a much bigger problem and every bit as debilitating. The difference is that dementia always progresses but depression can be prevented, treated and often cured, yet it gets almost no attention in our system, which focuses on so-called "serious and pervasive" mental illness, and that's a shame.

In Ontario there has never been a framework to address seniors' mental health and addictions, and we need one. We have to begin by dealing with the deadly duo of ageism plus the stigma of mental illness. We need public awareness and targeted education for seniors, family members and staff who work with seniors from the mental health perspective and from the seniors'

perspective. In fact, anyone who has contact with older adults should know what is normal about aging so that they can help to identify what is not normal or may be a mental illness.

We need more and better prevention programs. Seniors' centres, clubs and organizations, housing superintendents, as well as everyone who works with or cares about older adults need resources and help to understand the role they can play. Seniors can and want to play a significant role in helping to design systems that will meet their own needs. We are not using that wonderful population nearly enough.

We need to intervene early, and that means overcoming the self-stigma of older adults, making proper diagnosis more readily available by having more properly trained staff and then having direct links to appropriate services, not only medication, which is important and plays an important role—and by the way, older adults respond to antidepressants at twice the rate and do much better per person than other age groups, which is not well known—but we also need social support and people need someone who will listen.

We need specialized community mental health services, home support and intensive case management. You heard before the issue of services being cut off. The reality is, there is no law that cuts mental health services at 65. However, the services have the choice of whether or not to serve older adults, and many of the people who are working in community mental health themselves don't even realize that they can serve people over 65. We have lots of education to do.

When or if it becomes necessary or more comfortable for someone to live where more support is available, we need to consider supportive housing and assisted living alternatives, not only long-term care. Long-term-care homes as they are now are not resourced nor are they necessarily most appropriate for most older adults dealing with mental illness. Right now, long-term-care homes are dealing fairly well with people with dementia. People with other mental illness are not doing well in long-term care.

We need clear direction and leadership at the government level across many ministries. We need to clarify policies about whether or not adult mental health services can meet the needs of older adults or if we need a separate stream of services. For me, it doesn't matter at all as long as we meet the needs somehow.

I have a few suggestions for specific roles that people can take. The Ministry of Health and Long-Term Care certainly should be taking the lead on clinical services in the community and in long-term-care homes, as well as around home support. I'd like to suggest that the Ontario Seniors' Secretariat can take the lead on public awareness and seniors' education using peer mentors as models and trainers, which they do in many other spheres. The Ministry of Education has a large role to play in terms of training across disciplines. Mental health agencies need to educate their own staff and decide to what extent they can meet the support needs of their own community, if

separate services need to be in place or if there need to be combinations. Seniors' services can themselves act as early identifiers and work on the realms of prevention and reintegrating people into the community. Seniors themselves can certainly be identifiers and supporters, and all of us have a role as champions and advocates.

I'm leaving you with a copy of a user-friendly piece we did as the Older Persons' Mental Health and Addictions Network for your information, to show you how easy it is to get the information out. I want you to know that this was funded by the government. Almost 20,000 of these were handed out in a few short years and you have the last copies; I have literally three copies left. My card is on it. There's much more I would like to talk about. If anybody wants to talk about this, please be in touch.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for your presentation. We've got time for a few questions. Let's start on the government side.

Mrs. Liz Sandals: Yes, you mentioned a couple of ideas that I found really interesting and I'm wondering if you could expand on them. One of the issues for seniors with mental health disorders is clearly how you even get those identified and recognized, and you said seniors' services as identifiers. How do you see that working in question 1. Question 2: If you were to do supportive housing as distinct from long-term care, what would be the supports that you would need in supportive housing?

Ms. Randi Fine: In terms of the first question—now, I forget.

Mrs. Liz Sandals: Seniors' services as identifiers. I wrote it down.

Ms. Randi Fine: Well, that's cheating.

Laughter.

Ms. Randi Fine: Seniors' centres—I worked in one many moons ago—for example, are places where supposedly well seniors come, but people are well before they become not well. Depression in particular, which is this huge issue, is relatively easy to recognize when you know what you're looking for. We also know where the risk peak times are. If someone loses a spouse, for example, we know that we should be checking on that person, because out of five people who lose a spouse; two will develop a clinically significant depression. We could intervene. Seniors' centres know those people; they know who has had a loss, so that's one particular area.

There are programs of early screening and high-risk identification that are done in other constituencies, not in Ontario. We are picking up people that way, but we haven't tried that here. That's one way—and certainly education for seniors themselves about again, what's normal and what's not so that they can self-identify and they can help other people to identify. That's one.

In terms of supportive housing, we have, actually, wonderful models of supportive housing for people who have long-lasting mental illness. In fact, many of those people who are living in those places cannot live in long-term care. In Toronto, for example, we have LOFT Community Services; I don't know if you're aware of that. LOFT is a major supportive housing provider, and

in downtown Toronto has five buildings specific to seniors with mental health and addictions, many of whom have been in long-term care, couldn't function in long-term care, were sent back out into the community and really were very lucky to end up in supportive housing. They now have programs starting in the Jane and Finch area as well.

The services that they provide are intensive case management, but in the sense of very practical case management. So people have help with making sure that they have groceries, that kind of thing. There is often one meal a day. They live independently, but there is somebody there 24 hours a day, should someone have a crisis.

They have great research that's being done that shows that they reduce costs, they reduce hospitalization, and the most important part is that people are living dignified lives. They're independent to the extent they can be, but with supports should they need them.

Mrs. Liz Sandals: Thank you very much.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for your presentation, Randi. It was really nice of you to come today.

Did you have a question, Sylvia? A brief one?

Ms. Sylvia Jones: Thank you for coming, Randi. I wanted to specifically zone in on—you talked in your recommendations about peer mentors. We've heard a lot about that in other addiction and mental health treatments but not related to seniors' mental health. So, briefly, for the benefit of the Chair, can you sort of extrapolate on how that would work?

Ms. Randi Fine: Well, it does work. We've already had many, many instances. There are peer mentors in the areas of widows' groups, for example—sometimes, you know, they pair off and have a one-to-one. There are senior peer helper programs in a general sense around seniors.

One of the seniors' organizations in Ontario is taking on a role of developing a speakers' bureau, teaching seniors who have experienced depression themselves or as family members to go out and speak to others about that by way of education.

So there are lots of different ways that this could happen. It doesn't have to be formalized—that's the nice part of peer support—but it needs some coordination to happen.

Ms. Sylvia Jones: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you for coming today, Randi, and thank you for your patience.

Before we adjourn, members of the committee—we should try it at least, anyway, because we got off to a bit of a late start today in our pre-meeting. Staff have something here that may be time-sensitive, and that's on the discussion points for the report writing. We asked them to come back with an inventory of those programs that, as a result of the presentations, were deemed to be innovative programs. Some of that information's been easy to come by from the Internet; some of it's a little tough. So the first question they're asking is, would we be satisfied with an inventory for the time being of those

programs for which we can find details on the Internet, or do you want to include all the programs? France?

M^{me} France Gélinas: What I was thinking is that, the ones that you can easily find, sure, put them on, but give us the names of the programs that you think are innovative, because in the end, it could be that you will do a whole bunch of work for things that we won't deem were worth all that work. The flip side is, it could very well be that because some information is easily available, it will make it on to the list when, really, it was not that innovative or vice versa. So I think to prevent you wasting your time, bring the list forward so we can have a first say: "Don't bother with this"; "This is fine"; "We don't need three of the same. We'll pick one"—whatever. So then at least we'll have a better idea of the workload that we're putting on your shoulders.

The Chair (Mr. Kevin Daniel Flynn): Okay, thanks. Sylvia?

Ms. Sylvia Jones: That's fine.

The Chair (Mr. Kevin Daniel Flynn): You agree? Great. Any problems over on that side? That sounds reasonable?

Mr. Jeff Leal: Fine.

The Chair (Mr. Kevin Daniel Flynn): Great. At what stage in the process would you like to receive the inventory: before the interim draft report, or between the interim draft report and the final draft report?

M^{me} France Gélinas: As soon as you've got it.

The Chair (Mr. Kevin Daniel Flynn): So it's not important, just as soon as possible.

Interjection.

The Chair (Mr. Kevin Daniel Flynn): I wouldn't say it's not important, but there's no critical deadline to get it. Good. Thank you.

I mentioned—just before we go, this is something you can think about—that so far, we've heard from a number of people on a number of issues. Two issues that haven't come up a lot have been on gambling addictions—people just haven't come forward and really talked about it much—and the other is on sex addiction.

Ms. Sylvia Jones: At the very beginning we did.

The Chair (Mr. Kevin Daniel Flynn): Yes, but we really haven't heard a lot and it may be interesting to note those, because when you talk to people in the field, they talk about it a lot, and yet when we hear the presentations, it's not coming out a lot. It's just something, I think, to think about.

M^{me} France Gélinas: What was the second one?

The Chair (Mr. Kevin Daniel Flynn): The second one is sex addiction.

Mrs. Liz Sandals: I was going to say on gambling addictions that the gambling addiction research institute is in Guelph. I'm sure that if you contacted them, they would be delighted to come and present.

The Chair (Mr. Kevin Daniel Flynn): Yes. Okay, well, perhaps that's something—but it's just something that I think is noticeable by its absence.

Mrs. Liz Sandals: They're actually the government-funded body that's responsible for doing the research. I can tell Susan where to track them down.

The Chair (Mr. Kevin Daniel Flynn): Perfect.

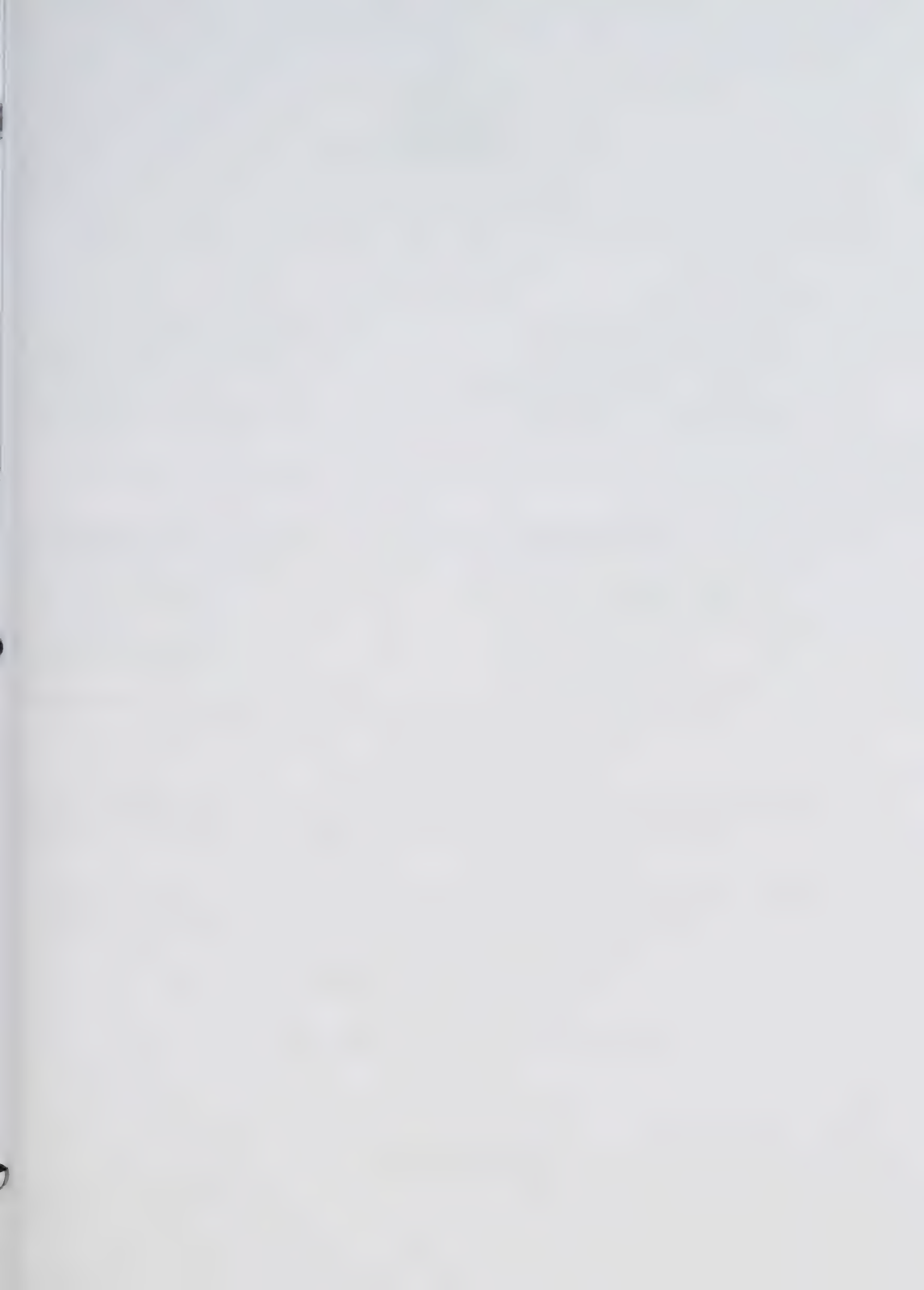
M^{me} France Gélinas: Maybe I got that information from another committee, but I thought we had received quite a few written submissions from problem gamblers. They didn't come and present, but I thought we had written—no? I got this through public accounts, not through you?

The Chair (Mr. Kevin Daniel Flynn): I can remember two or three people who talked about it. The

one group that talked about it were the people that were proposing we add a nickel to a drink—because that's kind of what we do with gambling, that part of the treatment is built into the business itself. But outside of that, I think I've only heard about it in passing from the presentations we've heard before the committee. Just something to think about.

Thank you. We're adjourned.

The committee adjourned at 1832.



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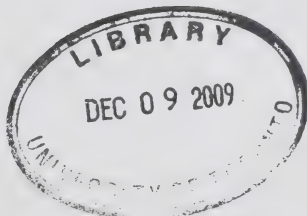
Mercredi 25 novembre 2009

Select Committee on Mental Health and Addictions

Mental Health
and Addictions Strategy

Comité spécial de la santé mentale et des dépendances

Stratégie sur la santé mentale et
les dépendances



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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

SELECT COMMITTEE ON
MENTAL HEALTH AND ADDICTIONSCOMITÉ SPÉCIAL DE LA SANTÉ
MENTALE ET DES DÉPENDANCES

Wednesday 25 November 2009

Mercredi 25 novembre 2009

*The committee met at 1605 in committee room 1.*MENTAL HEALTH
AND ADDICTIONS STRATEGYONTARIO ASSOCIATION OF NON-PROFIT
HOMES AND SERVICES FOR SENIORS

The Chair (Mr. Kevin Daniel Flynn): Okay, ladies and gentlemen. If we can call to order, if everyone can take their seats, I'm going to call for the first presenter today, and that is Donna Rubin from the Ontario Association of Non-Profit Homes and Services for Seniors. If you'd like to have a seat, Donna, make yourself comfortable. Perhaps you can introduce your colleague once we get going.

Just to tell you a little bit about our rules, everybody who has been asked to appear is given an equal amount of time, and that is 15 minutes. You can use that any way you see fit. If at the end of the presentation we still have any time left, we'll split that amongst the parties.

Ms. Donna Rubin: Can I just get clarification? I thought we were here with a half-an-hour slot, I was told, as an expert panel.

The Chair (Mr. Kevin Daniel Flynn): Oh, I'm sorry. Do you know what? You are, that's right.

Ms. Donna Rubin: So we go till—

The Chair (Mr. Kevin Daniel Flynn): You go till 4:30, but the same rules apply—actually, you'll go to 4:37. I wouldn't get hung up on this too much. You get half an hour. You can use that any way you see fit. If we do have any time left over at the end of the presentation, we'll try to get some questions and answers in.

Thank you for coming.

Ms. Donna Rubin: I'd certainly like to thank you for the opportunity to make a presentation to you on behalf of our members. I am Donna Rubin, the CEO of the Ontario Association of Non-Profit Homes and Services for Seniors, known as OANHSS. With me today is one of our board members, Dominic Ventresca, who is the director of senior services with the regional municipality of Niagara. He operates over eight long-term-care homes.

1610

We've provided you with a document that has the main points of our presentation for your reference. We've also provided for your consideration a detailed written submission that articulates our concerns in more depth.

For those of you who may not know OANHSS, we are the provincial association representing the not-for-profit providers of long-term care, services and housing for seniors. We have municipal and charitable long-term-care homes, non-profit nursing homes—and when I talk about seniors' housing, on the same campus a lot of our organizations may have seniors' apartments, life lease, supportive housing, a full continuum of services into adult day programs and things like Meals on Wheels and so forth.

One of the main points I want to make is that at least with the long-term-care homes, many of our members operate at the highest level of staffing. Government funds long-term care, as most of you know, but our members often operate with either charitable donations or municipal contributions. So when I'm talking about some of the issues and the challenges they face, you can assume that this applies even more so to other homes that don't enjoy those added contributions.

Just as an aside, this year we celebrated our 90th anniversary as an association, so we've been around for a long time.

Our member organizations operate over 27,000 beds and 5,000 seniors' housing units—and that is one of the areas where we've noted there's a huge gap in the system: insufficient levels of seniors' housing. I mentioned the continuum, and because of that, we are commonly known as a leader in this sector, because our members are providing the full continuum of care, which is why, I think, we wanted to share with you some of our insights across the system.

Let's move to the slide that says "Overview on Mental Health": We're very pleased that both this group and, of course, the minister's advisory group have been struck. We've had a focus on a lot of the mental health issues for some time. We'd like to work on the areas of risk reduction in the system, and we hope that the work of this group and the advisory group is going to lead to some real transformation and make some lasting change around the province. We've been at a number of expert panels before, and we really hope that this will come to fruition with some real changes.

If we just look at "Seniors Demographics," I think the point we're trying to make today is that seniors are not just older adults whose mental health problems can be addressed within generic treatment programs; they are a unique population. It's a growing population. Actually,

the number of seniors in long-term care who live with mental illness is a little bit of an unknown. Our current estimates are probably on the low side, mainly due to issues related to stigma or just lack of knowledge of seniors' mental health issues. So we're assuming that a lot of people are flying under the radar.

While mental health issues impact those over the age of 80 to a much greater extent than those in their 60s and 70s, we're not wanting to minimize the mental health and addictions issues for younger seniors—but it's the seniors over the age of 85 in our homes who we obviously see day to day.

The next slide: I just want to talk a little bit about some of the mental health issues common to the seniors we serve, and again, to show how their mental health issues are quite specific to this population. Dementia is very common in this population. Over 65% of the residents in long-term care have some form of dementia. Depression is often mistaken as a normal part of aging or a symptom of physical illness, yet if diagnosed correctly, it is treatable. And delirium can be easily mistaken for something else and can be fatal; therefore, a correct diagnosis is critical.

Our key concerns: Essentially, the homes and community services have great difficulty in maintaining the safety of residents and their staff members at this point. We've been signalling this for a number of years. Our staffing levels are low, and the number of aggressive incidents in long-term care, in particular, are occurring regularly.

To give you a little bit of an idea of the data experience in one long-term-care—well, I should say in one municipality that has five long-term-care homes. They were tracking the number of incidents, and, in 2008, over the five homes, they had over 250 acts of aggression, mostly resident to resident, and that's roughly just under one incident per resident per week.

I know that as you've been touring, you probably heard from a home in Nepean, Peter D. Clark, when you were in the Ottawa area, about their concerns around violence and aggression. Well, it was only a few weeks ago that there was a homicide in that home, resident to resident. That's on the heels of 2001, the Casa Verde nursing home incidents. We're just often realizing that it's a bit of pressure cooker in long-term care and this can happen at any time.

So the safety of our residents and the safety of our staff is a huge issue. Violence in the workplace is considered to be a priority amongst the Ministry of Labour, particularly with our sector, and it's one that we're very aware of.

But with diagnosis not always being—among doctors and service providers not often seeing what exactly is going on with someone, we see a lack of specialized knowledge specific to geriatric care in general and geriatric mental health in particular.

Some of our key concerns: Seniors are often returned to long-term care from hospital without full treatment and planning in order to comply with current legislation.

The bed-holding provisions right now require someone to be away from long-term care no more than a couple of weeks; I think it's 14 or 16 days at this point. So they may be in hospital for treatment and they'll lose their bed in long-term care unless they come back. That will change, hopefully, in the new Long-Term Care Homes Act; in the new regulation, they're looking at moving that to 21 days, but even at 21 days, it's still going to be an issue. So somebody's off to get stabilized and treated, and we may be pulling them back in just to hold the bed.

Hospitals are reluctant to admit long-term-care residents because of the possibility that once they've got them in the hospital, they may not be able to discharge them because they're too severe for the home to take them back. It's the same situation in the homes. We often have people who we should not be caring for and we need to discharge them and there's nowhere to discharge them to in the system.

So this gap of appropriate alternate settings is really an issue in our sector, particularly since we can't discharge without consent of the resident or their appropriate decision-maker. The community care access centres that evaluate and admit people into long-term care and take care of those kinds of transactions are not currently required to help us locate a more appropriate setting even if the resident is posing a severe risk to our residents and our staff, our homes.

We fully recognize that reducing ALC pressures is a huge concern for the ministry, but our concern is that if the resident is not a good fit for the home, we can't meet the safety needs of the individual and the other people we're supporting. So it's a huge issue for the homes, and they're kind of caught in the middle.

Further on the key concerns around the funding model: It doesn't currently support appropriate care for those with mental illness. We often identify—in our staffing situation, we've got one registered nurse on a day shift, and it could be up to 64 residents that they're supporting. They can't have eyes and ears everywhere at all times. When we have people with these kinds of needs, we need, in crisis situations, immediate approval of funding for supplemental staffing and any other resources that are needed. They have to be available and, they must extend until the CCAC can facilitate a better alternate setting or placement, if that's even possible.

1620

We've noticed quite a range in Ontario, different levels of expertise, depending on where you are in the province. Access to geriatric mental health outreach teams is inconsistent. Those far away from urban centres are really disadvantaged. Behavioural support and special care units are pretty rare. Actually, where they do exist, they're often in not-for-profit homes, because again, they're the ones who are providing added contributions; they might be topping up through the municipality. So we see a few of them, but they're not that common.

The other piece that I just wanted to touch on is that we're moving to a new classification tool, MDS/RUGS, a new care planning and assessment tool. It tends to

support complex continuing care. It doesn't weight and fund well the behaviours that we see exhibited through residents with mental health and cognitive impairment. So the new funding tool is a great tool, but we've been signalling and talking to government that it doesn't capture the behaviours that are exhibited by residents with cognitive impairment and mental health.

If we can move into our recommendations, we do believe that mental health services need to be integrated throughout the health system. It would be much easier to navigate and services would be much more accessible. Seniors have to be able to access them wherever they are, whether it's in long-term care, seniors' housing or in their own homes, so if they do move, they'll continue to move and have access to geriatric psychiatrists or geriatric mental health outreach teams—that the services follow the person.

As we noted earlier, we think that behavioural assessment and support units need to be more accessible across the province. The funding model does not typically support those units. It might not have to be a specialty in every long-term-care home for the average dementia, but severe mental health, I hear often enough—a lot of our members will say, "We can do it if we have the right resources." They're willing to do it, but they need more appropriate units, staffing, training and so forth, which we'll get into even further.

On the next sheet of recommendations: If there's still going to be a lack of alternate settings, we are going to continue to be in a problem situation, because we have people who should not be in long-term care. Once that continues to hit with the media and continues to be an issue, people are going to be afraid to come into the government-funded system because they're going to hear that it's not safe and say, "You can't protect my parent or my grandparent." So we need to find a solution to the fact that there are people who don't fit in our homes—and those are the severe cases; I'm not talking about the average person with mental health problems.

Again, resources should follow the individual.

There is stigma associated with age, dementia and mental health, even amongst seniors. We believe that educational campaigns aimed at the public, to raise public awareness, would be beneficial, but also campaigns directed towards professionals, because we have to start reducing misdiagnoses, increase recognition and collaboration with other caregivers, and improve treatment in this area. We truly want to create that "every door is the right door," to get appropriate services, but we have to educate even the caregivers.

We've been saying for years that we need more staff, but we need better-trained staff to work with this sector. We need education and training of both regulated staff and non-regulated staff. It is the PSW, the personal support worker, who does provide a huge amount of care in long-term care, and they need to be better-educated to work with this sector.

We should be training families and the volunteers as well, because there is so much that can be done if they're

knowledgeable. They can remain involved in the person's life in a meaningful way if they have that training. Training alone is not the solution to all the issues associated with this, but it can make a significant contribution and so would best practices in this field.

Other recommendations: We think a coordinator role would help seniors and their families to locate the appropriate level of care. It is very difficult to navigate the services in seniors' care, long-term care and what else is available through CCACs and so forth. It is hard enough—we see it even when our own administrators have to place their family members and they just suddenly realize how hard it is; they can't even imagine how the average family goes through it. So we have to have an inventory of the care that's out there; how people can access it; try to have a coordinator role in the system to assist people and have a sort of continued knowledge transfer in this area because there's quite a void.

In order to achieve a high level of success over time, we need to have some action plans with clear timelines and accountability, cost projections and funding and, of course, evaluation details in this area. There's quite a lot of work that can be done.

In conclusion, you know as well as I do, our population is aging, and if we don't address these unique needs as seniors in the near future we're going to exacerbate the current problems. I think that we're only going to increase the pressures that are already in the system, and not only does it make economic sense to take care of people in a setting that's probably less costly than hospitals, but I think we do have a moral obligation to address the safety issue. If nothing else, we have to deal with the safety of the people in our care. This is a huge concern for providers, and we need your help in order to signal that to the public and to the government.

I just want to thank you for the opportunity and end there. If you have time for questions, we'll be happy to answer those.

The Chair (Mr. Kevin Daniel Flynn): Well, that's great. You've left a lot of time. So we'll start with Sylvia.

Ms. Sylvia Jones: On page 4 of your presentation, you make reference to some of the aggressive actions that your members and staff are having to deal with right now. This is a subjective question, but I wonder if you could share with the committee: Do you believe it is because the mental health illness is not being treated, or do you think there is a different issue there with the aggressiveness?

Ms. Donna Rubin: Well, it's not always being treated properly, for sure, but we don't have the training or the staff to assist them in coping. So, for example, if Sunnybrook has a staff complement that can almost be one on one, they can take somebody with aggressive behaviours and they're able to calm them and work more closely with them. When they're in our environment—and as I said, we have one personal support worker to maybe 12 or 13 people—they're just on their own and they can get agitated; we don't have the staff to help control and calm them. There's an element of how many hands you've got

to deliver care; are they trained enough; do they know what they're doing; and we've got a bit of a microcosm now of what's on the street coming to long-term care, particularly with the psychiatric institutions that have been closed over time—people with schizophrenia, bipolar, all sorts of severe issues are in our long-term-care homes, but we don't have trained staff to deal with them.

Mr. Dominic Ventresca: I would say that, in addition, the professional resources of geriatric psychiatrists for example or even psychiatrists, as everyone knows, are scarce, and so using our example in the Niagara region where we have some hospitals with psychiatric units and then we relay to the Hamilton psychiatric, specialized psychiatric hospitals, those resources are not available at the home and sending people for that care is problematic. So it's a combination of lack of professional resources, which is of course the treatment piece, and then there's the management piece in the homes where our staff are not always best prepared to deal with these particular behaviours, also in terms of education and then of course in numbers.

1630

Ms. Sylvia Jones: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Domenic, France?

M^{me} France Gélinas: It's nice to see you, Donna. Are there examples in Ontario where things work good for seniors with either mental illness or severe mental illness? Are there case scenarios or units where if we had that, then they could really do a good job?

Ms. Donna Rubin: I'm going to let Dominic answer it because he's one of the few organizations that has a dementia care centre.

Mr. Dominic Ventresca: I'd like to think that the Niagara region has one of the better records for managing folks with dementia and other related disorders. Why I think we can make that claim in part is because we have a good collaboration among some of the various practitioners in the field, whether it be the Niagara Health System, St. Joseph's Hospital in Hamilton, the geriatric mental health outreach folks, the PRCs, the psycho-geriatric resource consultants, the Alzheimer Society.

We have a good collaborative group working, but in addition to that, we have been able to cobble together one key component of a good care package for a geriatric population with mental health needs, and that is a dementia centre, which has been the product of good local work in Niagara with the municipality contributing to the base funding of long-term-care beds. Also, the LHIN most recently has stepped up and really brought us to the level where we've got a well-funded and well-staffed dementia care centre. It's a small centre. It serves the entire Niagara region, servicing 31 long-term-care homes with over 3,000 beds, and also supports the hospitals and the community support service agencies that manage people in the community as well.

So it's an example of what can happen. It has been cited in the report of the Ministry of Health in 2007 or

2008—I forget which year that was—that identified that as a good model to have on a LHIN-wide basis as one of the components within the behavioural support services that are within a community. Every community can establish precisely what works for them, but there needs to be a provincial framework to guide the local communities so that local communities can come up with solutions locally but following a provincial framework.

M^{me} France Gélinas: So how does it really work on the ground? Are those specialized unit beds that people get transferred to until we have a treatment plan for the mental illness or their dementia? How does it work on the ground, or is this something that travels to their homes?

Mr. Dominic Ventresca: On the ground, it's one component in the continuum that's available within Niagara, in that there are 17 beds that are serving a purpose of behavioural assessment and also behavioural support. So up to 90 days, people can be transferred from other long-term-care homes.

The CCAC is a key component to make this work. People can be transferred from another long-term-care home where there are difficulties managing, where these residents are aggressive and injuring other residents or staff. They've been visited perhaps by the geriatric mental health outreach team members. Perhaps they've had some psychiatric involvement, but it's deemed that there are other ways of managing that behaviour, so they come to the centre for assessment. They can stay up to 90 days. If need be, they can stay up to another 90 days with a number of interventions.

There are certainly psychiatric interventions, but there are some non-pharmacological and non-psychiatric interventions. We've got additional recreationists there. We've got an OT now, through the last bit of funding from the LHIN. And with the specialized education, we require and we work with the unions on developing this, with additional credentials they have to have. Besides their usual RN or RPN or PSW credentials, they require a geriatric mental health certificate from the local college.

So that's one element of extra training, plus there's lots of support from the PRCs in terms of education which is fulfilling their role fully to provide these staff with the added bit of knowledge and expertise to manage folks, and then, when they return to their long-term-care home or to the community in some instances, we transition and provide that package or that set of information that worked in that setting to continue on so that we build capacity with the other long-term-care homes to manage in their own facility, closer to home from that regional centre that we've developed.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Jeff, and then Maria?

Mr. Jeff Leal: Thanks for your presentation.

Comsoc, of course, has closed the last of the institutions in the province of Ontario. We have many individuals with an intellectual disability, Down's syndrome. We have aging parents who are no longer in a position to look after their loved ones. What percentage in non-profit

long-term-care homes in Ontario would be represented by that group?

If you have somebody who has Down's syndrome at 40 years old, I know the challenge often is that sometimes their needs—because their medical condition can deteriorate significantly more rapidly than others.

Ms. Donna Rubin: We had figures from the Ministry of Health. Just a couple of years ago, there were about 1,200 in the system. They tend to be in their late 40s or 50s, who often have parents in their 70s. They're often coming with their parent into long-term care—and they transition very well into long-term care. They fit in better than other people with mental health illnesses because they're sort of taken care of. They live with the seniors in a very, I would say, happy kind of existence.

Mr. Jeff Leal: But in terms of staff training, because this is kind of a unique challenge—

Ms. Donna Rubin: Well, that's what we're saying: that there's no additional staff training in the average long-term-care home other than what people have cobbled together through their own opportunities. We're signalling that there needs to be a much higher level of understanding, and it can make such a difference.

The Chair (Mr. Kevin Daniel Flynn): Maria?

Mrs. Maria Van Bommel: I was reading your more extensive document just quickly, and you note that one third of older adults with alcohol addictions actually come to that in their old age. I'm just taking this a little bit further, because we do talk about mental health and addictions here: What are the situations around, say, prescription drug addiction and that sort of thing as well? When you say that one third of the adults who you see with alcohol addiction come to it in old age, is this self-medicating—you're suffering from depression, anxiety or whatever, and you decide to start self-medicating with alcohol and prescription drugs and that sort of thing?

Mr. Dominic Ventresca: I think a lot of what happens is what you've identified already. There are additional pressures that come with aging, whether it be loss of a spouse, loss of independence, uncertainty around living arrangements, the trauma of potentially moving into a long-term-care home and so on. So I think those are contributing factors.

One of the points made in the paper, of course, is that it's a heterogeneous group. So we can't summarize too much about what happens in most cases, but I think you've identified a number of the issues already. I think it really is an individual matter. Nevertheless, it does happen to a greater extent because of some of the additional challenges faced by many older people.

Mrs. Maria Van Bommel: Are you seeing an increase in that? Are you noticing it trending upwards?

Mr. Dominic Ventresca: I probably wouldn't be the expert to comment, except to say that with increasing longevity, we're seeing more happen in mental health issues because people are living longer, where perhaps people would have died earlier due to some physical ailment. So probably there is a greater increase in that phenomenon.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Dominic, and thank you, Donna, for coming today. We do appreciate it.

MARYSE BÉLANGER

The Chair (Mr. Kevin Daniel Flynn): We're in a bit of a quandary now for the next presenter. In about nine minutes or less, we're going to have to go and vote, and the next presenter has 15 minutes to present.

Maryse, you could start and we could do maybe eight or nine minutes, then we could come back and ask you questions, and that way we won't be tying you up as much as if we made you wait 15 minutes.

Ms. Maryse Bélanger: Not at all. I don't mind.

The Chair (Mr. Kevin Daniel Flynn): So you'll get 15 minutes. You use that any way you see fit.

Ms. Maryse Bélanger: You tell me when you have to leave to vote.

The Chair (Mr. Kevin Daniel Flynn): At about eight minutes you'll see us all sprint out of the room, and don't take it personally. It's all yours.

Ms. Maryse Bélanger: It's okay. I've been a journalist on Parliament Hill for five years, so I know the drill.

Thank you very much for having me today. I'm Maryse Bélanger. I'm here representing myself. I'm going to talk to you about perinatal mental health, which involves pretty much postpartum depression. The reason why I'm talking to you about it is because, when it comes to identifying problems in mental health, especially in mental health systems, we never hear about postpartum depression. It's not mentioned in the Every Door Is the Right Door paper, presented in June; neither is it mentioned in the Mental Health Commission of Canada's paper for a national strategy. So it's a bit worrisome when you think about the fact that 16% of women who have children suffer from severe postpartum depression. I don't know if it's because people don't think it's serious or what, but it's a bit alarming. So that's why I just want to mention what I know about postpartum depression.

Obviously, you've noticed that I'm a francophone, so sorry for the mistakes in English, but just cope with me.

I just want to mention also that postpartum depression is the leading cause of disease-related disability in women, according to the World Health Organization. So it is the leading cause for disability.

I want to talk about untreated postpartum depression. It has a permanent impact on the infant's development. What do I mean by that? I mean that the child is going to be impacted if the depression is not treated. If the mother is not treated, there's going to be an impact on that child for the rest of his life, and it can have very severe consequences later in life.

An untreated postpartum depression can increase the risk of:

—the severity of the depression, so the cost, at the end: Often, the mother is going to think, "It's just going to go away. It's going to get better." If it doesn't get

better, that's where it costs a lot more money. Sorry, I have a sore throat, so I'm going to have some water.

—maternal morbidity: One thing that, as a news producer, I've covered a lot are murder-suicides.

—adverse effects on the mother-infant relationship: When we're talking about the attachment, the bonding, between the child and the mother, if it's not treated, that relationship will not be proper for the rest of their lives. That means the mother is going to resent that child for the rest of her life, thinking the child took away part of her life and it's the fault of the child, where the mother has to somehow come to a conclusion to the fact that she was depressed. So she and her child are both impacted by the depression. The child was not the cause of that depression, but if you don't treat the woman, that's what she will think for the rest of her life.

—the vulnerability to neglect the child: That means the parents could neglect the child.

—emotional abuse by the parents; and

—parenting and marital breakdown.

I want to talk also about the father. Can you imagine a father who discovers how powerless it can be for a man to not be able to do anything for the woman he loves and who sees that it's not going anywhere? So it's very devastating for the fathers as well, and that could lead to the placement of the child into the care system.

So we're seeing the cost of an untreated postpartum depression increasing really fast here. Eventually, it could lead to the emotional state of the infant being impacted and the cognitive development being impacted.

There are multiple barriers as to why screening doesn't happen often by health care specialists. Often, it's time constraints. It's easier to write a prescription than to listen to someone for an hour or so. It's also caused by the clinicians' discomfort with psychiatric disorders—you've heard that before on this committee—and the lack of knowledge about the resources to screen women.

You have to go?

The Chair (Mr. Kevin Daniel Flynn): We're going to have to leave in about a minute or so. If you could just choose a nice place to stop, we'll start up when we come back.

Ms. Maryse Bélanger: I'll just give you the stats for the survey on family physicians by the Best Start program. Sixty per cent were comfortable with making a diagnosis of postpartum depression, so we've got to wonder about the other 40%. Only 22% were aware of the common screening tools—22% knew what to do—78% felt they needed more resources and 81% said they wanted to learn more about postpartum depression. These are the people caring for the women.

So please go vote, think about it and we'll be back.

The Chair (Mr. Kevin Daniel Flynn): When we come back, you've got about nine minutes left to talk to us.

The committee recessed from 1643 to 1655.

The Chair (Mr. Kevin Daniel Flynn): Okay, let's call back to order. We do have a quorum; I'm sure the others will join us in process.

You've got just over nine minutes left, Maryse, so use that in any way you see fit. If there's any time at the end, we'll just split it.

Ms. Maryse Bélanger: Okay. I was telling you that there are still 40% of family physicians who are not comfortable making a diagnosis of postpartum depression. Even when women are referred for treatment, that doesn't mean they're going to comply with their treatment. Imagine a woman with a newborn: All you're thinking about is your breastfeeding timing, naps and all that. The last thing you want to do is wrap that kid up and go for a session with a psychiatrist. That's really the last thing you want to do. It is not suitable, and that's why a lot of women are going untreated, even if they are diagnosed in the first place.

As you know, hormones affect women in many ways. I'm not going to make jokes about it today, but we all know that hormones have a big impact on women's lives. Women are more likely to suffer from mood disorders during and after pregnancy than at any given time in their lives, because hormones are highly involved in pregnancy. Like I said, 16% of all women who have children will suffer from severe postpartum depression. According to Stats Canada, if you do the research, there were 138,000 births in Ontario in 2007. That means there were 22,000 women who suffered from severe postpartum depression in 2007. If we look at breast cancer in Ontario, just to give us an idea, it's estimated that 8,500 women suffered from breast cancer in 2007. So we need more money in mental health, for sure. They have the good-paying ribbon campaign. We need to find something serious, a very good campaign for mental health.

1700

Some 70% to 80% of mothers diagnosed with postpartum depression, if they are treated successfully, will recover. That's the good news. That's why we need to invest in funding and the delivery of adequate services for the mothers and their families. The problem right now is the lack of coordinated systems, as you've heard. I'm sure many representatives have mentioned that many times.

What's needed specifically for postpartum women and families who are living with postpartum depression? I'm just going to mention diversity to start with. We want to make sure that the services are culturally competent, given the high rates of postpartum depression and low rates of social support for immigrant women and refugee new mothers. If you think Ontarians have it bad, just imagine yourself coming to give birth in a different country.

What we need, as well, is the creation of centres or units for patients and service providers. We don't have day treatment units or centres and in-hospital care to ensure that all care providers and professionals know how to assess women, because obviously, with the survey, we know that they are not sure about how to go about that. So we need a centre that will focus their attention on that and give the information about it to assess and treat.

We also need all health care providers to be involved. I'm talking not just about psychiatrists and psychologists, but also midwives, obstetricians, pediatricians. They should all be involved in screening women for postpartum depression.

We also need intensive treatment units for severely ill women and their babies. Can you imagine just giving birth to your baby and, because you have to be treated for severe postpartum depression, we just say, "Sorry, we can't accommodate your child or your husband. They will have to leave, but you'll have to stay with us"? It's just not serious. We have to have intensive treatment units to accommodate that reality.

I'm also going to talk about screening. I mentioned it a little bit. I think the well-child visits with the pediatrician and the postpartum gynecologist visits are key and instrumental in early identification of postpartum depression. It should be mandatory. It should be part of their service. Right now, they do it as a courtesy. It's not part of their mandate. We check the woman's belly but not her head, which is totally ridiculous. It's a little bit like everything else: We go to the dentist, but we don't go to check our head every year.

There are no guidelines for screening in the province either. Health care providers should be informing all pregnant women—I'm going to talk about the high-risk factors first—of the high-risk factors for postpartum depression. With all my reading and research, I came up with, if possible—pregnant women should be told. I'm going to send you my document later. Sorry, I didn't bring it today. It's all there. It's something that is possible. It would need to be adequately reviewed by peers, but that's a start.

We should tell the women; we should inform them: "If you have suffered from sexual abuse, there's a very high risk for you, during your pregnancy or after, that you will develop postpartum depression." As a woman, if you know these things, you can at least know what you might be getting into. But not knowing, I think, is very silly at this point, and that's what society is doing. It's like, "Oops. We don't know about mental—oh, it's just happening. Let's hope it's not too bad." The reality is, we can inform women and they can follow and recognize the symptoms, and it won't be that bad, or it can be not too bad.

Guidelines and treatment: There are no official guidelines in the province for treatment of postpartum depression, or treatment during the pregnancy. I'm talking about medication. There's no official line about whether we should medicate a woman with depression during pregnancy or not. The stats are there; research has been done by Motherisk that proves that a woman left untreated for depression during pregnancy is far worse off, as is her child, than if she is treated with medication. The impact of medication is, in a way, a ridiculously—it's not a big worry, when you think of the very serious consequences that the untreated depression will have in the child's life.

The Chair (Mr. Kevin Daniel Flynn): You have about a minute left, Maryse.

Ms. Maryse Bélanger: Sure, I can do that. I just have two more pages.

You all have my document, so you'll be able to see what's needed. You've heard from many people what's needed in the system. Everybody wants a piece of you, but that's okay.

All I want you to remember is that postpartum depression is real; it's affecting one woman in five. Therefore, every woman with a big belly that you see, there is one in five who's going to have depression. I don't think we see that as being a problem. I think, as a society, we should see that as being a serious problem that could be, and should be, and can be resolved.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Maryse. That was a wonderful presentation. Sorry for the interruption in the middle.

Ms. Maryse Bélanger: It's okay.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much. Unfortunately, there's no time for questions, but thank you very much for coming here.

Ms. Maryse Bélanger: Okay. If you want to e-mail me the questions, I'll be glad to answer them.

The Chair (Mr. Kevin Daniel Flynn): Okay, and you're going to get us some written information.

Ms. Maryse Bélanger: Yes, I will, for sure.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming.

CONCERNED FRIENDS OF ONTARIO CITIZENS IN CARE FACILITIES

The Chair (Mr. Kevin Daniel Flynn): Our next presentation today is Concerned Friends of Ontario Citizens in Care Facilities. Phyllis and Lois, if you'd like to come forward and make yourselves comfortable. You have 15 minutes to present, and we don't have to leave during your presentation.

Ms. Phyllis Hymmen: I was very carefully noting that.

The Chair (Mr. Kevin Daniel Flynn): That's right. You've got to have a degree in math to chair this committee.

I'm going to leave that to you. We don't need any more time. Fifteen minutes; you use that any way you see fit. If there's any time at the end, we'll ask you some questions and then we'll take off and vote.

Ms. Phyllis Hymmen: Thank you very much.

The Chair (Mr. Kevin Daniel Flynn): Thank you.

Ms. Phyllis Hymmen: Concerned Friends of Ontario Citizens in Care Facilities really does appreciate this opportunity—

The Chair (Mr. Kevin Daniel Flynn): If you could identify yourselves for Hansard so we know who is who when we're recording it.

Ms. Phyllis Hymmen: Okay. That was coming later, but anyway, I'll do it right up front. I'm Phyllis Hymmen. I'm the president. Today I'm accompanied by Lois Dent, who is the past president.

We are aware, from hearing the tail end of the OANHSS presentation, that your attention was drawn to this area earlier this afternoon.

Just to tell you a little bit about ourselves, for almost 30 years we have been a volunteer consumer group that undertakes advocacy at both the system and individual level to improve the quality of care in our long-term-care homes. In order to retain an independent perspective, Concerned Friends is funded solely by our memberships, donations and the occasional grant.

I'm sure you've heard before, in the earlier presentations before you, that there are now approximately 622 long-term-care homes across the province, with some 75,000 residents. These homes, as again I'm sure you are aware, are regulated and funded by the Ministry of Health and Long-Term Care.

In our presentation this afternoon, we're going to describe the needs and challenges that the long-term-care sector currently faces, and we'll suggest some possible partnerships to address the current needs and the challenges that Ontario faces over the course of the next 10 years.

1710

I speak from some personal experience, as I first became acquainted with the long-term-care system when my mother, who was so proudly independent, developed dementia and could no longer live on her own. We had had no prior experience as a family in this area.

And so we come to the needs, as we see them. Of the approximately 75,000 residents currently in Ontario's long-term-care homes, a reported 60% to 70%, or some 45,000 to 52,500, suffer from Alzheimer disease or a related dementia. This really frames the care that they require.

The caregivers of these residents, from the personal support workers, registered practical nurses, registered nurses, physicians, social workers, activationists, physiotherapists, occupational therapists, dietary and house-keeping staff, all require knowledge and skills to deal with dementia management. The behaviour of these residents can be very challenging and can, in some circumstances, be of danger to themselves, staff and fellow residents. This has been evident in the sad deaths in 2005 of two long-term-care residents who were attacked by another resident. This led to an inquest that resulted in recommendations. Unfortunately, there has been another incident like this in the current year, and for this an inquest is likely to follow.

As can be seen from the number of long-term-care-home residents with great needs, and the list of those needed to care for them, there are funding needs to provide the quality of care that we all would want.

In the future, more skilled caregivers in all categories will be required for a growing aging population, as indicated by figures reported by the Ministry of Health and Long-Term Care's health systems strategy branch. By 2019, 10 years from now, projections for Ontario's aging population by Statistics Canada and the Ministry of Finance indicate that just under 10% of the population

will be 65 to 74 years of age, and that's an increase of some 5% from 2009. There will be further increases in populations aged 70 to 84, and to those over 85. This represents over 15% of the total population. With initiatives such as aging at home, the current trend of residents entering long-term care as older, sicker and frailer will increase even more over the course of the next 10 years. This is underscored in the report of the special Senate committee on Canada's aging population released in April 2009. The specialized care that residents will need to deal with their mental health will increase as well.

That brings us to the challenges. There is a challenge for attracting people to enter fields such as gerontology, geriatrics and long-term care. It is difficult to attract people to areas where they will be dealing with the elderly who have hard-to-handle behaviours, those who may be seen as past it or as having lived their lives, in other words, that stigma of aging. Attracting qualified nurses and doctors is difficult when the work is demanding and the salaries in hospitals are more attractive. Personal support workers who provide much of the hands-on care often take this role because the training required is relatively short. We have heard that some take this training as they are urged to do so in order not to be on Ontario's social assistance rolls. In addition, because of the pay levels, it is currently not unusual to have personal support workers working in two long-term-care homes to meet the financial needs not only of themselves, but of their families.

Disseminating and acquiring knowledge of the long-term-care system and its mental health care is a challenge. It is something that one doesn't like to think about as being needed by them or by a loved one. It is thrust upon a loved one when they are no longer able to care for themselves, or when the family caregiver is no longer able to cope.

While there is increasing knowledge about Alzheimer disease and related dementias, as well as treatment for depression, the challenge for more knowledge and approaches to care remains. This challenge will increase as the population lives much longer than in the past.

With the diverse population of Ontario, there are the challenges of meeting mental health needs of long-term-care residents from a variety of cultures and the customs and characteristics that accompany them.

When most long-term-care residents are elderly and have some form of dementia, there are challenges for the care of younger residents who also require the care that homes provide. There is the additional challenge for older residents who are mentally alert and competent but who require care to keep them mentally active and to avoid depression.

That brings us to partnerships. In addition to the essential aspects of the workforce and the funding for long-term care, collaborative partnerships are essential. This includes acquiring and sharing knowledge about long-term mental health and the techniques of care. There is great potential in the continuation of the existing collaborative partnerships between the Ontario govern-

ment, capable residents, family members, the scientific and medical communities, and the long-term-care associations. It is possible that new partnerships will emerge over the next 10 years.

So, more specifically, these partnerships include: the Ministry of Health and Long-Term Care's performance improvement and compliance branch; local health integration networks—the LHINS; community care access centres—CCACs; regional geriatric mental health outreach programs; the long-term-care associations that I mentioned, the Ontario Long Term Care Association and the Ontario Association of Non-Profit Homes and Services for Seniors; Alzheimer Society of Ontario and the Alzheimer Knowledge Exchange; a new group, Ontario Caregiver Coalition; residents' councils and family councils.

In conclusion, as the Select Committee on Mental Health and Addictions, you have the opportunity to influence the mental health care of loved ones who are now unable to receive the care they require to live in their own homes. We have outlined the needs, challenges and partnerships for long-term care. Concerned Friends recommends that you consider the essential funding, staffing and education required as you consider the mental health of seniors and, particularly, for all those living in long-term-care homes. The mental health strategy, and the addictions strategy that goes with it, that will be developed, will impact all of us, and particularly for us in the future, when you and I have similar needs.

Lois and I would be pleased to answer any questions that you may have.

The Chair (Mr. Kevin Daniel Flynn): That's wonderful. Thank you very much, Phyllis. You've left time for probably one question from each side, starting with France.

M^{me} France Gélinas: I don't know if you were here when I asked the question of OANHSS, but I'll ask you the same question. Are there best practices out there, are there services or long-term-care homes where you know that we have gotten it right, it really works well there and there's something to be learned so that it can be repeated in other long-term-care homes?

Ms. Phyllis Hymmen: Well, one of the things that's currently happening that is an example of the great collaboration between the people who have responsibility for the care in homes, the people who are receiving the care, the residents and the families, and the related associations that go with that, is the Ontario Health Quality Council's initiative now on quality improvement, and best practices is certainly going to be a part of that. I know it's a term that's used.

As Concerned Friends, what we have done in the past is, because we received the compliance report for every inspection that's done in all of the long-term-care homes, we've been able to look at the unmet standards, so that we can look at an individual home and say, according to what we have reported from the most recent compliance report and what we know of the history of this home, this is one that we would recommend.

I personally can speak very positively about the home where my mother was. It was certainly not perfect, certainly has the staff needs, the education of staff needs, and all of that comes back to funding, which is in very short supply, which we fully understand. But as we go forward, and these collaborations that have developed with the discussions around Bill 140, the act and now the regulations so that very often when we sit around the table we are sitting with the same people—so from the compliance transformation that's being undertaken by the Ministry of Health and Long-Term Care, by the most recent activities of the Ontario Health Quality Council, I think we're leading to where we want to go.

The Chair (Mr. Kevin Daniel Flynn): Questions? Liz.

Mrs. Liz Sandals: Could you give us an idea of what you would see as the necessary characteristics of a program for someone who has very serious behavioural issues related to either dementia or mental health? As a family member, what characteristics would you be looking for?

Ms. Phyllis Hymmen: I'm going to start quickly and then I'll pass it over to Lois so that she has a chance. What I'm looking for is someone who has the knowledge to care for that person. But I'm so aware, as a family member—fortunately, I have a background in psychology so that when my mother developed dementia I was able to pull some of that, but what I was certainly aware of is that what I learned in graduate school had developed greatly since then, so there's really the education need—a program that has an education need, ideally before, but also staff who are able to cope in terms of knowing strategies. That's where the partnerships that I referred to come in.

Ms. Lois Dent: I'd just like to bring your attention to one kind of example of what I think is a concern. A best practice is, for example, the program at Sunnybrook Hospital. It's a—*the name isn't coming to me now*, but it's a small unit that is specifically designed for caring for people with behaviours that are too difficult to manage in a regular long-term-care home. They have a higher staff level. It's just an amazing program. It's a behavioural unit, is what it is. The staff there, who are well-trained and know how to deal with many of these behaviours, learn how to best manage each individual. Then, ideally, they can go back to the long-term-care home with some advice and support as to how to deal with that person. I think we need many more of those.

The Chair (Mr. Kevin Daniel Flynn): We're going to move on to Sylvia.

Ms. Sylvia Jones: In your partnerships section you make reference to a number of agencies, but the one that I'm surprised I saw was the CCACs. Can you tell me how the long-term-care homes would—where that partnership would develop? What do you envision in that partnership?

Ms. Lois Dent: I think that comes to mind particularly to avoid, perhaps, horrendous incidents like that one that was mentioned in our presentation where a newly

admitted resident attacked and actually killed other residents. The reason—

Ms. Sylvia Jones: So at the placement level?

Ms. Lois Dent: Yes, it's the placement. The CCACs need to get the information that they need and they need to get that information to the homes so that especially in a crisis admission, as this was, they would be ready to deal with it.

Ms. Phyllis Hymmen: And that's the very beginning. That's where you have to start.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much, Lois. Thank you, Phyllis, for coming today. Wonderful presentation.

We're going to recess so we can vote in about four and a half minutes. We'll be back shortly after that.

The committee recessed from 1721 to 1733.

ONTARIO COMMUNITY OUTREACH PROGRAM FOR EATING DISORDERS

The Chair (Mr. Kevin Daniel Flynn): Okay, we can call back to order. I think we have the whole committee here, just about.

Our next speaker is the Ontario Community Outreach Program for Eating Disorders. Gail McVey, come forward. Have a seat, Gail. Make yourself comfortable. We shouldn't have to leave on you. You should get 15 minutes all the way through. Use that as you see fit. If there's any time at the end, we'll just split it.

Ms. Gail McVey: That's great. Thanks very much. I'm Gail McVey. I'm a psychologist and a research scientist at the Hospital for Sick Children, down the street, as well as with the University Health Network. I am here today in my role as director of the Ontario Community Outreach Program for Eating Disorders. That's a provincial training program in the area of eating disorders that's funded by the Ontario Ministry of Health and Long-Term Care. You have with you a bookmark that has our website, should you have any questions around that.

I wanted to just spend a few minutes describing eating disorders and the treatment of them here in Ontario, have an opportunity to identify two existing gaps and to see if there are opportunities to integrate with mental health and addictions.

Eating disorders are complex psychiatric and medical complications and disorders. They're actually the third most chronic illness among youth. They require highly specialized treatment and comprehensive, multidisciplinary care. In-patient or hospital stays are long, and outpatient follow-up is even longer. For example, we often have clients coming into the hospitals for three to six months, followed by at least two years of outpatient care for them to reach recovery. Intensive, family-based work with nutritional rehabilitation alongside weight restoration and medical and psychiatry stabilization are essential first key elements of treatment for clients to maximize the benefit of outpatient care in order to address the underlying issues to prevent relapse.

In Ontario, we have a very innovative, coordinated system of specialized care, which is one of a kind. Our network is dedicated and has standardized assessment and treatment protocols across all pockets of Ontario—across the 14 LHINs. Our network is not yet fully developed to meet the heavy demand for specialized services. In the meantime, as we work to expand our network, we are being strategic and collaborative to make sure that any new investment is allocated to the expansion of programs that can help relieve pressure on the entire system; in other words, looking at ways in which it can have the biggest impact on the province.

We have well over 85,000 individuals who suffer from eating disorders in Ontario, and that includes only those that we know about, as only 30% present for treatment. The longer eating disorders persist, the harder they are to treat. We are seeing eating disorders in children as young as seven and eight years of age, both male and female.

The cost of eating disorders are multiple. On the one hand, there's a strain on families who have to leave their jobs to participate fully in treatment. Family-based treatment is recommended. Secondly, there are financial costs to families related to travel and accommodation, as families need to travel away from home to access intensive programs. Currently, we only have intensive programs in Ottawa and Toronto. There's a further strain on the clients themselves—on their physical and emotional health—often leading to social isolation, where they're having to take a hiatus from their work or their schools. A burden is felt on all family members as the mortality rate for eating disorders is 10% to 20%, due to heart failure or suicide.

In addition to a need for additional in-patient beds for both adults and pediatrics—we currently have 20 beds for adults and 16 beds for pediatrics in the entire province; these beds are always full, with overflow of clients seeking treatment out-of-country, which is costly; not very effective, in most cases; and further disruptive to families.

1740

In addition to a need for in-patient beds, we have two significant gaps in our system. One is a residential care program, which is nonexistent right now, to house clients whose eating disorder symptoms have subsided but require residential care for the complex, co-morbid conditions that underlie the eating disorder.

We cannot rely on the existing mental health system, due to stigma and fear of caring for clients with eating disorders. As a result, these clients take up in-patient eating disorder beds for the treatment of co-morbid psychiatric disorders and/or complex family situations that need to be attended to.

If we were to house them in a residential care program integrated with continued specialized eating disorder treatment, we would be able to free up the in-patient beds, allowing us to rotate clients more efficiently throughout our in-patient programs here in Ontario.

A second gap is the lack of treatment for concurrent eating disorders and addictions. Eating disorder programs

don't have the resources to treat addictions and vice versa, leaving these desperate and high-risk patients without care, heightening their vulnerability for relapse or suicide risk.

We would like to initiate dialogue with your committee members to discuss ways in which we can combine our resources to better meet the unique needs of individuals with these complex and life-threatening disorders. Solutions can start with collaboration across sectors or ministries.

I want to leave you with two success stories as examples for a rationale for expansion and possible cross-collaboration across ministries.

One is an example of pediatric care. At Sick Kids four years ago, we had a young client, 12 years of age, who had a very severe eating disorder with complex comorbid conditions. She was treated over the course of four years, with several in-patient stays at Sick Kids, eventually sent to the US for residential care, away from home and from family, and returning very ill here to Ontario.

Sick Kids partnered with Youthdale, which is funded by a different ministry, the Ministry of Children and Youth Services, with an agreement to offer support to Youthdale staff for the treatment of her eating disorder. We integrated family-based eating disorder treatment and medical stabilization to the client and her family while she stayed at Youthdale, closer to home.

This child, four years later, at the age of 16, has now fully integrated back into school and is on her way to recovery.

Another example is in our adult services. At Credit Valley Hospital, we have an adult eating disorder program that includes a day hospital and an in-patient program. Also at Credit Valley is an excellent day hospital for addictions, the only one in Ontario.

The eating disorder program will often send their clients for treatment in this addiction program. Once they finish the intensive part of their addiction treatment, and after four months of follow-up care, they're invited back to the eating disorder day treatment program down the hall at the same hospital.

It's great to have the substance abuse expertise in the hospital at the same location where we have an eating disorders program.

Credit Valley has submitted a proposal to the Ministry of Health and Long-Term Care for two more beds at Credit Valley so they can be used in a more flexible kind of way for medical stabilization and the treatment of concurrent disorders. This could be a step along the way to meeting the special needs that we have for people with concurrent disorders.

The Chair (Mr. Kevin Daniel Flynn): Thank you. You've left a lot of time. Let's start with the government side. Liz?

Mrs. Liz Sandals: You raised a number of questions, but a couple that I'm wondering if you could address: first of all, the concept of treating the whole family—if you could talk a little bit about that. Then, you're talking

specifically about a youth program. What is the cut-off age for youth programs that you're familiar with? What's available in terms of the transition from youth programming to adult programming?

Ms. Gail McVey: Our network is comprised of programs that treat pediatric eating disorders. That would go up to 18 years of age. Our adult programs, available across the province, would start treatment at 18.

Where possible, we try to transition clients, because they often continue to need treatment beyond the pediatric stage. There is no existing transitional program in Ontario. Right now, our programs really work in a collaborative way to try to smooth out that transition as much as possible.

In the 20 years that I've been working in eating disorders, I've been very optimistic about family-based treatment, because it's showing up as something that is giving families an opportunity to restore a bit of empowerment in the treatment of their own children. Traditionally, we would take them away from their families and put them into in-patient units, and when the children returned to their families, they would often relapse.

What we're finding very helpful and evidence-based is involving parents in the treatment from the get-go. Not only are we doing individual family-based treatment, but we're doing multi-family therapy as well, where we treat six families at once, looking for innovative ways to complement our in-patient programming.

Mrs. Liz Sandals: But the model, then, would be that the child or children would be in-patients at the program, and the families would need to co-locate in that area and would be coming in during the day for treatment sessions.

Ms. Gail McVey: Correct. Sometimes, children need medical stabilization in a very acute way, so whether they are participating in an in-patient program, a day treatment program or an outpatient program, family-based treatment is recommended. For example, we have a case where a family from Thunder Bay is getting treated in Ottawa. These are long treatments—three to six months minimum—so the family has to relocate to Ottawa, pay for their travel and accommodations, and take time off from work to be able to help their child recover from this life-threatening disorder.

Mrs. Liz Sandals: That's a huge commitment.

The Chair (Mr. Kevin Daniel Flynn): A short question from Jeff.

Mr. Jeff Leal: Thanks, Mr. Chair. Do you work with school boards, at all, for early identification?

Ms. Gail McVey: Yes. The other hat I wear is as a researcher, where I've dedicated my work to the prevention of eating disorders. I spend a lot of my time working with the Ministry of Education and with the 36 public health units across the province to standardize prevention techniques in the schools.

The Chair (Mr. Kevin Daniel Flynn): Sylvia?

Ms. Sylvia Jones: Thank you for your presentation. I want to ask you a little bit more about concurrent disorders and access to care. I understand—we have heard

this from other people—that trying to find treatment for concurrent disorders is almost impossible.

Ms. Gail McVey: Exactly.

Ms. Sylvia Jones: That being the case, what do you treat first?

Ms. Gail McVey: This is the issue why clients have difficulty getting access. When they come to an eating disorder treatment program for treatment of an eating disorder, part of the criteria is not having addictions, because right now, we barely have enough resources to treat the actual eating disorder and all the things that go along with that. So we need resources where we can actually treat both concurrently. There's one at CAMH, the Centre for Addiction and Mental Health, which has had some good success. Replicating something like that in different areas of the province would probably be a good short-term solution.

Ms. Sylvia Jones: Do you know how many beds there are at CAMH that are doing this?

Ms. Gail McVey: They don't have beds; I believe it's all outpatient at this point.

The other part of the answer is, when people go for addiction treatment, there's a real lack of—we've specifically trained practitioners to work in the area of eating disorders, but often in other areas of mental health care, people don't have the skills to offer the treatment for eating disorders, and they're often left untreated.

The Chair (Mr. Kevin Daniel Flynn): France?

M^{me} France Gélinas: Would you know the percentage of concurrent: an eating disorder and an addiction?

Ms. Gail McVey: I can give you that information in terms, perhaps, of the research, but I know that anecdotally in Ontario, when I speak to the clinicians who work across our 30 eating disorder programs, it's not uncommon to see as much as 50% of clients who have both.

M^{me} France Gélinas: I'm interested in the prevention of eating disorders that you do with the health units. Is it through the development of a tool, that public health nurses go through the school? How does it work?

Ms. Gail McVey: Absolutely. I could have brought another bookmark for you. What I want to mention is that all of this is being done through research, and as scientists, we're very committed to doing knowledge translation. So in addition to doing the research, we often will share strategies with different stakeholders so they can use them.

We've developed best practices, and then we've made them accessible through community-based workshops that are funded through this outreach program, as well as an online training and curriculum program. To make it user-friendly for teachers, we've matched all of our strategies to the Ministry of Education's learning outcomes, so that teachers don't have any extra work; this is integrated into their normal workload. One of those websites is called AboutKidsHealth, The Student Body, and I'd be happy to share that with the committee.

1750

The Chair (Mr. Kevin Daniel Flynn): Gail, I have a brief question. I've had a number of constituents come into my office who are parents of children with eating disorders, and I think to a person they've complained about the treatment they receive when presenting themselves at emergency rooms when a crisis—

Ms. Gail McVey: Yes.

The Chair (Mr. Kevin Daniel Flynn): I'm sure that doesn't happen at Sick Kids, but in a typical Ontario hospital, as part of the outreach, do you talk to the health care practitioners themselves?

Ms. Gail McVey: Yes. We've reached out to a good 5,000 practitioners, if not more, across Ontario, where we do community-based workshops for people who will not necessarily devote their careers to the treatment of eating disorders but who could perhaps identify or incorporate better opportunities to support them into their care. Probably the ones who are the hardest to target are the physicians. We continue to have difficulty, particularly in emergency rooms, which is often the first point of contact.

So some of our network members have come up with some innovative physician education projects—completely unfunded at this point, but a strategy to try to reach out to the family health teams. But certainly, one of the gaps is to reach out to emergency rooms across the province.

The Chair (Mr. Kevin Daniel Flynn): That's wonderful to hear. Thank you very much for your presentation. We certainly appreciate your coming.

Ms. Gail McVey: Thanks very much.

ONTARIO FEDERATION OF COMMUNITY MENTAL HEALTH AND ADDICTIONS PROGRAMS

The Chair (Mr. Kevin Daniel Flynn): Our next presenter this afternoon is the Ontario Federation of Community Mental Health and Addictions Programs: David Kelly, executive director. David, come forward and make yourself comfortable. You have 15 minutes, like everybody else. Use that any way you see fit, and we'll use up any time you don't.

Mr. David Kelly: Okay, great. Thanks very much.

If you notice, the title of my presentation today is Embracing Challenges Together, and that's sort of the theme, because as you're understanding and hearing from all your other presenters, the complexity of issues in mental health and addictions requires all of us to come together to solve those issues.

I thought I'd start by giving you a general idea about the Ontario Federation of Community Mental Health and Addictions Programs. We work with over 240 providers who are providing the full range of services in mental health and addictions. Withdrawal services, community withdrawal, housing and treatment services are housed under the federation.

I wanted to include our objects of incorporation, our vision statement and our mission statement so you understand why I'm here today and why we're coming. I'm just going to highlight some of the words in that: collaborative; enhancement of the system; accessibility; flexible; comprehensive and responsive to the needs of individuals, families, communities; partnerships; high-quality and effective services.

We come to you today to build a better mental health and addictions system. We are a transfer payment agency of the Ministry of Health, and we are also a member organization. But in our membership we truly believe in building that better mental health and addictions system.

In this time period, there's an unprecedented focus on mental health and addictions issues. We have this committee, the all-party committee on mental health and addictions in Ontario; we have the minister's advisory group, which I'm proud to say I'm a member of; we have priorities in many LHINs, local health integration networks; and we have the Mental Health Commission of Canada also working on these issues. If you look to the poverty strategy and the soon-to-be-released housing strategy, many of the other works the present government has passed also reflect the needs and issues faced in mental health and addictions.

I come today first to give you special thanks; recognition must be extended to this committee for its work. Being out having public hearings like this—hearing from communities and travelling across Ontario—is helping to build the momentum we need to overcome all these challenges. We encourage collaboration between this committee and the minister's advisory group, and also the use of work being done by the Mental Health Commission to leverage more support for people in Ontario.

A quick example of that is the recent announcement of the housing research study being conducted by the Mental Health Commission, which is resulting in people being housed and services being provided to homeless individuals with serious mental illness in order to do research to demonstrate the success of different models in providing those services. There are great opportunities with all of this work, and we need you to grab and reach those opportunities.

However, all that success also means changes for all the parts and pieces of addictions and mental health services in Ontario, and I'm here to tell you that providers across the system—and I think families and consumers are encouraging us to go on, but we are ready to collaborate and coordinate. We want to be accountable for the services that we provide not only to you, the government, as funders, but also to the people who access those services. We want to focus on harm reduction and recovery. We just had a cited example of where we see blocks in the system where often people with an addiction have to have that addiction resolved or stop using a substance before they can access services. What that means is many, many people never access the supports and services that will help them get past that addic-

tion. We want the system to focus on recovery and harm reduction, and we want to integrate right from that hospital system, that emergency room, out to the community. It's crucial and key to your success and the success of the report from this committee.

I come to you now, though, to tell you that it's just too great for us as providers; it's too great for families and persons with lived experiences. We need coordination of governments and their different ministries to focus programs impacting mental health and addictions. Hats off to Minister Caplan for bringing together 12 different ministries, ministers and their ADMs to look at how they fund and the issues in mental health and addictions. We will still wait for the results of that work, but just having justice, education, Comsoc, health and other ministries coming together to talk about mental health and addictions, how they fund it and what actions they are taking is making a difference already. We encourage that work and urge you to encourage the government to continue that work.

Too often, we have different initiatives coming at us, and people with serious mental illness and the focus and the dollars are lost because we are not coordinating that work. What happens at the Ontario disability support program has a direct impact on people in the community, the services that are being provided. Those links have to be made. We obviously want the coordination of different health and social services and to end all the silos within health care. We've brought addictions and mental health together as a first step. We now need to bring other components of the health care system together with mental health and addictions and make sure those supports are available to them—for example, family health teams—so we can better build a system.

The next point is about investments in community-based services and the broad determinants of health. I would be a fool to come here and not acknowledge and recognize the incredible problems we are facing on an economic level. I would challenge you that we cannot use that as an excuse again. I'm going to give you a quick example. Depression impacts women on a much higher level than men, and we know a precursor to depression is obviously often low self-esteem. Girls and boys up to the age of 12 often have the same levels of self-esteem. When puberty hits, often girls' self-esteem will decline dramatically, which then starts building them up to be more susceptible to depression in their later years. If we were to put self-esteem programs targeting girls and young women in our schools, in 20 years we would hopefully—and could—see the levels of depression decline. That's why I go back to our theme about us coming together, because this is not a one-off solution; it's not a four-year solution. We're talking a long-term commitment. Honestly, I will say the field is looking to this committee and the minister's advisory group to help us get there.

Understanding that we have huge challenges on funding levels, let me say that the continuing ballooning of the health care budget—the solution lies in community services, those services that wrap around the broad

determinants of health. Housing is a solution for mental illness and addictions.

Investments in the structures that support these services: Every presenter who has come to you has talked about different programs that are having successes, different standards and policy frameworks that are needed. We need those structures and we need those investments now to be able to make a difference within the 10 years. We need standards, we need evaluation tools, we need assessment tools, we need to use research, not just academic research but lived experience research, to better build a system and we can't wait for the economy to get better for those processes to start.

1800

Understanding that your report may not be available within this next budget system, I would hope or love to see some advice on the next budget coming from this committee. One of the other real, true commitments we need to see is a commitment from the government, opposition parties and the civil service to follow through on implementation.

This committee came together realizing that this is a non-partisan issue, that this is impacting all Ontarians, and the solutions and the ideas are so complex that we had to come together. We could fill this room with reports, coroner inquests, human rights tribunal outputs; we could fill this room and then wonder why the system has not changed. We need to follow through on implementation.

You may ask, "That's all well and good, what is the federation doing to help change that system?" I just want to flag a few things that we are doing that we've provided for the committee to feed into that. First, I want to talk about consumer-survivor initiatives. If we are going to a recovery-focused system, if we are going to be making sure that people with lived experience and serious, mild or moderate mental illnesses or addictions are empowered and are going to be on the road to recovery, we have to make them central to our service delivery. We've brought to you today the results of a joint project with consumers from across Ontario to give you some advice on how to build consumer-survivor initiatives and utilize well-documented and researched work that shows the outcomes of peer support. For example, people with a serious mental illness helping someone with a serious mental illness—the impact of that is tremendous and results in huge savings to the health care system as a whole.

Also included, embracing cultural competence in mental health and addictions, which is about getting supports out to all providers of mental health and addictions to understand that they must meet the cultural needs of all Ontarians. Unfortunately, we are not equipped as a field to do that work and it's crucial to have positive outcomes in mental health and addictions services.

We also brought together our work that we're doing around meeting the accessibility standards for customer service. Those standards have been coming out from the office of disabilities and the federation is presently

working with providers to ensure that they are meeting all of those disability standards. You will soon be hearing from us, as your committee does your work, on primary care, emergency room diversions, and we are presently working with our partners in mental health and addictions to start looking at how we can implement the change that is needed to build a better system.

I just wanted to also give a special recognition and a thank you to this committee. Putting aside the partisanship and developing an all-party committee in Ontario to look at mental health and addiction issues is putting us on the road to success. I also want to let you know that we are here as an organization to ensure a more accessible and responsive system of supports and services to all of Ontario. We're here as a resource for you and a resource for all Ontarians.

The Chair (Mr. Kevin Daniel Flynn): Thank you for a wonderful presentation. Unfortunately, we don't have time to get a complete question in, but I think we got your point very clearly and we appreciate your offer of assistance.

Mr. David Kelly: I will say we will be back to the committee with some more of that work on primary care and emergency rooms.

The Chair (Mr. Kevin Daniel Flynn): And we're planning a joint meeting with the advisory committee. I think we've finally got a date set before the end of the year.

Mr. David Kelly: That would be excellent.

The Chair (Mr. Kevin Daniel Flynn): Thanks for coming, David.

RAKESH MODI

The Chair (Mr. Kevin Daniel Flynn): It appears our 5:30 presentation is not going to be here, so our next presenter today is Rakesh Modi. Rakesh, if you'd like to come forward. Rakesh has asked if he can film his presentation. I have no objections to that, unless any member of the committee has any objections. No?

Make yourself comfortable. Like everybody else, you get 15 minutes. Use that any way you see fit. The floor is all yours.

Mr. Rakesh Modi: Thank you for giving me this opportunity. My name is Rakesh Modi. I'm an Ayurvedic physician and an acupuncturist by profession. I'd like to present to you a combination of Ayurveda—which is an Indian health care system, one of the oldest systems in the world—and acupuncture, and some yoga.

What is Ayurveda? Ayurveda is the traditional ancient Indian medical science, the origin of which can be traced back to the Vedas, which are the oldest available classics of the world. Vedas are the ancient books of knowledge, or science, from India. They contain practical and scientific information on various subjects beneficial to humanity like health, philosophy, engineering, astrology etc.

Ayurveda is the only ancient independent scientific system of medicines. In the medieval period, however,

the system faced utter neglect at the hands of foreign rulers. Some authentic literature was destroyed in these turbulent times. Even then, Ayurveda contributed to the public health system due to its safest and most effective herbal formulas and easy availability. The seers who initiated Ayurveda inducted in it sufficiency, soundness and sustenance, and that is why it survived.

The literal meaning of Ayurveda: Ayurveda is a holistic healing science. "Ayu" means life. "Veda" means knowledge or science. So the literal meaning of the word "Ayurveda" is "science of life." Ayurveda is a science dealing not only with treatments of some diseases, but is a complete way of life. This becomes clear when we see the meaning of "life." As mentioned above, Ayurveda is a science of life, so to know more about it, we must know what life is. Life, according to Ayurveda, is a combination of senses, mind, body and soul. So it's clear from this definition of "life" that Ayurveda is not only limited to the body or physical symptoms but also gives a comprehensive knowledge about spiritual, mental and social health.

Names of the Ayurvedic/ancient herbs which are useful for mental disorders: Number one, which is most commonly used in India for mental issues and hair loss or hair-related issues, is called brahmi, which is an Indian name. The Latin name is *Bacopa monnieri*. The drug class is brain tonic, hair nourisher and rejuvenator. The indication is for depression, hysteria, epilepsy, insanity and other mental disorders. Another simple thing that is available anywhere around the globe and that we are all familiar with is the walnut, which is called *Juglans regia* in Latin. The drug class is brain tonic, antiseptic, stimulant, expectorant. If you open a walnut, it looks exactly like a brain. Some more herbs are also available.

There is an eightfold classification of the Ayurveda:

- (1) Kayachikitsa, known as internal medicine and therapeutics;
- (2) Kaumar-bhritya, for gynecology and pediatrics;
- (3) Shalyatantra, which is surgery—in 200 BC, in India, we used to do plastic surgery without anaesthesia;
- (4) Shalakatantra, which is ENT;
- (5) Bhutavidya, which is spiritual therapy and psychiatry;
- (6) Vishatantra, which is toxicology;
- (7) Rasayana, which is rejuvenation therapy;
- (8) Vajikarana: virilification therapy.

1810

Now the treatment process in Ayurveda: What do we do? How do we do it?

—We do a pulse diagnosis to find out what imbalance is causing the factor and figure out the body type of the person, according to the country's own climate zone.

—We suggest proper diet as per the body type, customized for each individual.

—We provide herbs.

—If it's required, we also add PanchaKarma, which is rejuvenation therapy. It consists of full-body massage; medicated steam bath; Shiro Dhara, which is oil dripping

on the forehead, as you will see in the next slide; head massage; nose and ear therapy; and enema.

This is one of the most effective treatments we have found, which is called Shiro Dhara. It is a flowing stream of medicated warm oil on the forehead, as you can see, after a head massage. Shiro Dhara is a sacred Ayurvedic healing practice that involves placing a continuous fine stream of warmed oil on to the forehead. It has become one of the most sought-after treatments in the spa industries of Europe and North America, but this system is originally from India. It is a great, helpful tool for any mental disorders.

Now let's come to acupuncture. We have found that 15 to 20 continuous sessions, with a duration of 30 to 60 minutes per session, can help you get rid of alcohol addictions, food addictions, nicotine addictions, drug addictions—any type of addiction. But it requires some commitment from the client as well. When a client comes to us and wants to quit smoking or any other addiction, we ask them, "Sir"—or ma'am—"how much willpower do you have? Because if you don't have any willpower to start with, it's not going to help." Sometimes, as I say, it's 15 or 20 sessions. With continuous, regular sessions of acupuncture, a person can quit smoking within 15 to 20 sessions.

At the same time, when we add acupuncture, we use one point which is available at the centre of the head, the crown, which is called the master point of the body. It treats all types of psychiatric and neurological disorders, including addictions.

Also, we use the heart point, available on the wrist line of your hand, which is very useful for improving willpower for addiction therapy and mental disorders.

At the same time, we suggest a couple of others things, like yoga and meditation, some kind of asanas and breathing exercises to get more oxygen flowing to the brain.

Also, if they have dental coverage, we tell them to go to clean up their teeth and gums. Why? Because the tongue moving over the teeth, touching your gums and teeth, will send a message to your brain to go and have a smoke. Why? Because a nicotine layer stays on your gums and teeth. If you remove that, it will help clients get rid of addictions probably 20 to 35 times faster than in normal conditions.

There are small tricks available. If you also help them with some herbs, and sometimes with combinations of Ayurveda, yoga and acupuncture, a person will come out of it faster.

And it could be cost-effective, because not only are they getting rid of the smoking, but at the same time, when using these points on the ear, which are most likely the lungs and the large intestine—because generally, when people are smoking, the toxins are contained in the lungs and large intestines—we help them shake up their body so they can get rid of all the toxins from the system naturally. Slowly, gradually, they can go over 100% of their willpower and then they can quit smoking, or food, or sex, or shopping, or any type of addiction.

Thank you very much. That is the end of my presentation.

The Chair (Mr. Kevin Daniel Flynn): Thank you. That was very interesting. The first question, I think, is from France.

M^{me} France Gélinas: It was most interesting. Very different from the other presentations we've had, and I thank you very much for coming here.

Mr. Rakesh Modi: You're welcome.

M^{me} France Gélinas: The people who go and seek treatment through you—I kind of recognize you from the picture—do they have to pay for it, or is there insurance or something?

Mr. Rakesh Modi: If they have acupuncture coverage, we give them all the information. Either they pay from their pocket if they don't have any insurance, or, because I'm a certified acupuncturist, I can give them a bill for acupuncture treatment. Then, yes, insurance generally pays for it, so there's no problem.

M^{me} France Gélinas: And if we look at somebody with alcohol addiction—I realize there are no guarantees in life or anything, but would you be able to tell the clients that come to see you, if they go through with the 15 to 20 sessions, what the percentage of success is?

Mr. Rakesh Modi: As I just mentioned, we always ask a client beginning with one question: "How much willpower do you have?" Let's say that you're drinking and your husband, your wife, a brother or sister is forcing you, it's not going to work. We want your passion—100% involvement in it. If they say, "I have 15% willpower," and if they come continuously and follow all the restrictions and all the diets or whatever, definitely they will get a 100% result.

Actually, when we did research in 1997 in Sri Lanka with homeopathy and acupuncture together—according to our own understanding, a general smoker can quit smoking within 10 days with this type of therapy. When it comes to alcohol, it also depends. When we ask a question—we also ask a second question: "How much are you drinking?" or "How much are you smoking?" So based on how long you were smoking, we may give them—"Okay, ma'am or sir, you will be out of this habit in 15 sessions."

Generally, what we do is—because you asked me if it's going to be cost-effective for them—we say, "Okay, we'll give you 15 sessions, but it's capped at the 15 sessions. If you have to go five sessions more, you don't

pay for it." We only charge for up to 15 sessions, because we know that it could be quite a lot of money for them to go through.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Rakesh. Let's move on. Anybody on this side? Maria?

Mrs. Maria Van Bommel: I noticed that you brought a device. Is that your warm oil—

Mr. Rakesh Modi: Yes.

Mrs. Maria Van Bommel: Can you sort of show us a little bit—

Mr. Rakesh Modi: Sure. Definitely.

The Chair (Mr. Kevin Daniel Flynn): You're trying to get a spa treatment out of this, aren't you?

Mrs. Maria Van Bommel: No, but I might need one. I just saw that you brought it in, and I thought, "It's interesting," but I didn't know what it was.

Mr. Rakesh Modi: That is the unit that we were saying—it's this one right here. I just brought it because it's—so it doesn't move, it doesn't fall on anybody. What happens is, you lie here. About four inches down your head—this is your forehead, and it's oil continuously dripping on the forehead; then, it dries through and collects at the bottom. After that, we do the full head massage and just help you with it.

Mrs. Maria Van Bommel: How long do you lay under that?

Mr. Rakesh Modi: They last between 15 to 45 minutes. But it's a very soothing effect. Honestly speaking, it's very hard to explain, but when you go through it, it's out of this world. I cannot write an essay on it. When you explain, when you go through it—we have seen people before and after. I'll tell you that 95% of the people under this treatment are falling asleep—they're tongue is out, they're snoring and you have to wake them up: "Sir, your time is up."

Mrs. Maria Van Bommel: I would fall asleep too. I'd be very relaxed.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today. It was a great presentation. We really appreciate you taking the time.

Mr. Rakesh Modi: Thank you very much.

The Chair (Mr. Kevin Daniel Flynn): Thank you, members of the committee and everyone who presented today. That's our last presentation of the day. We're adjourned.

The committee adjourned at 1815.

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Select Committee on Mental Health and Addictions

**Mental Health
and Addictions Strategy**

Comité spécial de la santé mentale et des dépendances

**Stratégie sur la santé mentale et
les dépendances**



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SELECT COMMITTEE ON
MENTAL HEALTH AND ADDICTIONSCOMITÉ SPÉCIAL DE LA SANTÉ
MENTALE ET DES DÉPENDANCES

Wednesday 2 December 2009

Mercredi 2 décembre 2009

*The committee met at 1606 in committee room 1.*MENTAL HEALTH
AND ADDICTIONS STRATEGY

The Chair (Mr. Kevin Daniel Flynn): If we can call to order, ladies and gentlemen. Welcome to all our guests. This is a meeting of the Select Committee on Mental Health and Addictions. We have a number of people presenting before us.

Just to outline the rules a little bit, everybody's got 15 minutes. You can use that time any way you see fit. If, at the end of the 15 minutes—or before the end of the 15 minutes—there is any time left over, we'll try to share that amongst the members who are present for a discussion.

ASSOCIATED YOUTH SERVICES OF PEEL

The Chair (Mr. Kevin Daniel Flynn): Having said that, I'm going to call forward Kelly Henderson, executive director of Associated Youth Services of Peel, if you'd like to have a seat and at some point introduce your colleague. The floor is all yours. Make yourself comfortable, and thank you very much for coming.

Ms. Kelly Henderson: Thank you. Good afternoon. My name is Kelly Henderson and, as the Chair indicated, I'm the executive director of Associated Youth Services of Peel. With me today is Lisa Bachmeier, one of the clinical managers at our organization.

We are a multi-service organization, working with young people and their families involved in the child welfare, youth justice and children's mental health sectors. In reference to children's mental health, we have been providing support since the mid-1990s in the homes of our clients and in the community. I appreciate the chance to address this committee today and would like to take this opportunity to offer messages about three key themes relating to children's mental health: service integration, the needs of marginalized youth populations, and sustainable funding.

First, service integration: In our community, and I'm sure in many others across the province, we clearly recognize that in order to share our responsibility of supporting young people and their families, we must ensure the integration of services cross-sectorally. Although many of us as service providers exist within differing

mandates and policy frameworks, we realize that the needs of one youth could span many sectors, and the responsibility of ensuring there is integration lies with us as professionals and not with service users.

To exemplify this, I would like to talk about how proud we are as an organization at AYSP to be the community agency lead for our student support leadership initiative. This is an interministerial project which incorporates services provided through education, children's mental health and youth justice. Our community is experiencing a great deal of success with our initiative, not only in how mental health connects with education and youth justice but also how we have expanded that framework to include a broader range of service partners. This has taken considerable time, varied expertise and a significant commitment to planning, with a shared vision that we will do better for children and youth and our community when we work and problem-solve collectively. We have experienced strong success, but we still have work to do.

An opportunity exists to continue this momentum and the momentum of other such initiatives, through a shared philosophy and vision of success for our youth and by interministerially continuing to place responsibility on policymakers and service providers to work collaboratively as a system of support. This would include assurance to joint problem-solving and decision-making at all levels, and an understanding that these processes and outcomes will be monitored and evaluated for success and accountability.

Second, the unique needs of marginalized youth: This will be discussed by examining the needs of the transitional-aged youth population, the homeless youth population and the lesbian, gay, bisexual and transgendered—who I will refer to as LGBT—youth population. When speaking of transitional-aged youth in this context, I'm referring to youth who are 16 and 17 transitioning to adult mental health services. When working to support transitional-aged youth experiencing significant mental health issues, one of the greatest barriers is the existing age range under the Ministry of Children and Youth Services, which dictates children's mental health support to a young person only until the age of 18. If we could change one thing, we would change that ministry definition of "youth," and we would change it to a more broadly accepted definition: up to the age of 24.

In our work with young people, we realize the transition to adulthood needs to be recognized as a unique time

in a young person's life, not a point in time but rather something related to individualized developmental processes. The chronological age of an individual could be 18, but developmentally and emotionally, they could be functioning at a much younger age. Under the current mandate, we have to end service at 18 years, regardless of level of functioning, which could impede a smooth transition to the adult service system and undermine success.

If there was an opportunity to apply a more flexible framework to who is able to obtain children's mental health services, it would be a more inclusive structure which allows individuals with significant mental health issues the time and opportunity to progress at their own pace into adulthood and the adult service system, resulting in better outcomes. This would not be the case for all youth; if they could successfully transition at age 18, they would. This speaks to those youth who would not be successful in that transition and who require ongoing support and expertise from the children's mental health sector. As service providers, it would still be important for us to continue to build partnerships with the adult service system. However, the flexibility would enable plans to be developed which meet the unique needs of individuals and respect their current capabilities.

Another marginalized group of young people are homeless. When working to support homeless youth with significant mental health needs, one of the greatest barriers is lack of affordable and supportive housing. Although our experience is in the Peel community, we believe this issue exists in other communities as well. In reference to affordable housing, our starting point begins with access to Ontario Works. In helping youth to obtain OW, we are aware of the rule that the young person must have an address to obtain support, and an address cannot be secured until proof of the youth's ability to pay is substantiated. Part of our work with homeless youth is to advocate on their behalf to access these funds; however, in the absence of an advocate, youth become frustrated and give up trying to obtain something which appears to them to be inaccessible, often resulting in no shelter.

Once a young person has been approved to receive support through Ontario Works, they soon discover the housing allowance afforded to them is not consistent with the market. As a result, they end up choosing between rent and other basic needs, including food. They often are only able to obtain substandard living accommodations in conditions which are not safe. This results in increased transience, driven by their need to find a safe and supportive space. If they do stay, they may be exposed to antisocial and criminal activity and harassment, including sexual harassment, a particular concern for young females and LGBT youth. These conditions, along with their limited access to nourishment and safe slumber, further serve as a barrier to school and/or work attendance. Additionally, for those youth with persistent mental health needs, there's a lack of supportive programming to allow them to maintain their housing.

In reference to emergency shelters, many work within a framework of zero tolerance for substance use. For

those youth experiencing concurrent disorders, it is another barrier to access. Often, the youth in Peel must travel to Toronto or other regions to find shelter, which limits their ability to maintain school or employment and isolates them from their existing support system, factors so important to their well-being.

Another specific population of marginalized youth includes those who identify as LGBT. When working to support LGBT youth with significant mental health issues, the greatest concern is disparities in health. For the purpose of this presentation, I will focus on mental health and well-being.

When reviewing statistics, we see that the rate of suicide in LGBT youth is three times greater than in the overall youth population. The rate of depression in LGBT youth is three to five times greater than in their heterosexual counterparts. An estimated 30% of LGBT youth have issues with alcohol abuse; 25% of youth whose parents react negatively are disowned and forced to leave their homes; 28% of LGBT youth drop out of high school at some point in time. LGBT youth are five times more likely to be attacked and three times more likely to need medical attention than heterosexual youths.

LGBT youth often experience the same struggles as the transitional-aged youth population and our homeless youth population. They have, however, an additional layer of marginalization, making them a very vulnerable population. They often experience homophobia and transphobia in the form of bullying and harassment, being victimized in their homes, schools and communities, which serves to further isolate them.

In our community, we receive project, time-limited funding to begin to address the needs of LGBT youth. The success of this initiative has been the result of working together, sharing the responsibility of building a service framework specific to this youth population, and building the capacity of the community to respond.

Overall, the needs of the LGBT youth population must be recognized to a greater degree and be identified specifically and on an ongoing basis in any strategy addressing the mental health needs of our youth.

As a final point on marginalized youth, I would underscore the importance of ensuring that our work with this population—in fact, all youth involved in our many systems—has as its foundation interventions which are evidence-based, and that outcomes are proven for success.

Now I'll move to my third point: sustainable funding.

AYSP was one of the four children's mental health agencies reviewed by the Auditor General of Ontario in 2008. Duly noted in the value-for-money audit is the assertion that core funding for children's mental health services across the province has been eroding for the past decade, resulting in reduced services for children and youth needing mental health support. Without a doubt, funding has not kept pace with clearly identified community need, and the process has damaged the development of infrastructure and administrative capacity as it relates to human resources, finance, evaluation and so on,

despite program growth and increased complexity in service delivery across the system.

Although there are often benefits to one-time and time-limited project funding, when it is used to begin programs, create community capacity and expectation and then is terminated, the ability to create a sustainable system of service and support is severely undermined. Moving forward, it is imperative that funding for children's mental health is based on assessed need and population. The mental health of our young people is fundamental when considering their current and future success. I propose that significant increased investment in children's mental health now will minimize costs both financially and socially in the future.

I thank you for this opportunity.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much. You've left a little bit of time for questions, maybe one for each of the parties. Let's start with Christine or Sylvia.

Mrs. Christine Elliott: I'd just like to thank you very much for coming today. Certainly a lot of the issues that you've highlighted are things that we have heard about, and we understand particularly the need for safe, affordable housing and the fact that children's mental health has not been receiving the attention that it deserves. So certainly those thoughts are foremost in our minds.

The Chair (Mr. Kevin Daniel Flynn): Go ahead.

Ms. Sylvia Jones: You mentioned that you received some one-time funding for an LGBT group.

Ms. Kelly Henderson: Yes.

Ms. Sylvia Jones: Where was that funding from?

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Ms. Kelly Henderson: That was through the child welfare secretariat, through the community capacity building funding. Our local children's aid society had identified it through their needs assessment, that work with LGBT youth in our community needed to be enhanced, so that was part of that funding envelope.

Ms. Sylvia Jones: And it was one-time for—

Ms. Kelly Henderson: It's fiscal, so we have benefited from it for the last two years. We applied to the Trillium Foundation and were successful in that bid as well, but again, that's time-limited project funding.

Ms. Sylvia Jones: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you. France?

M^{me} France Gélinas: I too would like to thank you for the work that you do, and thanks for coming here.

You're right: The Auditor General talks about lack of funding and it eroding. For your agency, can you share with us the budget that you have, and if you were able to secure more funds, have you given any thought as to how much that would be and what difference it would make?

Ms. Kelly Henderson: Our agency budget is approximately \$6.5 million. About half of that is dedicated specifically to children's mental health. The rest of our programming is relating to youth justice and some work with child welfare.

We have thought about, not specific to our organization, the top three priorities we would have for funding, although we could certainly generalize that to our organizational setting. That would be funding for community planning and service integration, such as student support leadership—because of the time and the expertise that's required for that, specific dollars that are made available to allow us to do planning would be beneficial; services for marginalized youth, as indicated in my presentation today, are lacking and we would want to see that increased; and funding support for the implementation of evidence-based practice would be something that we would see as being important.

M^{me} France Gélinas: Thank you.

The Chair (Mr. Kevin Daniel Flynn): For the government side, Liz?

Mrs. Liz Sandals: We've mentioned a couple of times funding for LGBT youth. Could you tell us a little bit about the programs you were actually able to do when you had that funding?

Ms. Kelly Henderson: I think I might turn that over to Lisa Bachmeier, who's our clinical manager and manages that program, just around the specifics of that.

Ms. Lisa Bachmeier: What we currently offer is the Youth Beyond Barriers program. We provide support for youth from age 12 up until their 18th birthday. With the Trillium funding we were allowed to extend it to their 19th birthday. But we provide weekly youth support groups, one-to-one support, and also facilitation to appear at monthly support group. There are also some Web-based resources because we know that's how the youth are really accessing the services.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming.

COMMUNITY NETWORKS OF SPECIALIZED CARE

The Chair (Mr. Kevin Daniel Flynn): Our next speaker this afternoon is Liz Froese. Liz, if you'd like to come forward and make yourself comfortable. There should be some clean glasses and some water there. Mark, if you'd like to come forward as well.

Ms. Liz Froese: Hi. I'm Liz Froese. I'm the coordinator for the Southern Network of Specialized Care, and we're very thankful to have the invitation today to come and speak to you.

I'd like to just introduce the people who are with me today. Mark Dorsey, at the far end, is a family member, and he will be presenting his perspective as a family member. Marc Hadida is here to answer your questions. He's a consumer who lives in Toronto. We will be sending you a copy of a videotape. He's going to videotape his story for you. He's a little bit anxious, and so we thought it would be easier to do it that way and he's graciously agreed to do that. So we'll send that to you in the future. To my immediate right here is Tony Vipond, who is the executive director of Community Living

Huron. He's also the co-lead for the Community Networks of Specialized Care, central region.

Mr. Tony Vipond: Thank you, Liz, and thank you to the committee today. The goals for our presentation today are to inform the select committee on the role of the Community Networks of Specialized Care in the province of Ontario, to outline the challenges faced by people who have a dual diagnosis, to present recommendations for change, and, most important, to put a human face on the impact of failing to adequately serve people with a dual diagnosis.

Community Networks of Specialized Care: In 2005, the Ministry of Community and Social Services recognized that people with a dual diagnosis and their families or caregivers were not being well served by the existing uncoordinated service structures. In May 2005, four regional networks were created and funded by the Ministry of Community and Social Services: the northern network, the southern network, the eastern and the central network. The mandate of the networks is to improve accessibility for those with a dual diagnosis; to improve coordination and integration so that services and supports from a number of programs, organizations and sectors are working together with people and their families to make a difference; and to improve accountability.

Dual diagnosis refers to people who have a developmental disability and a co-occurring mental health problem or challenging behaviour. Thirty-eight per cent of people with a developmental disability also have a mental health problem. People who have a dual diagnosis have more severe symptoms, are more likely to have co-occurring medical conditions and have fewer resources available to them. The most common problems are mood disorders and challenging behaviours.

Some other facts:

- children with a developmental disability are five times more likely to be abused;

- 77% of adults with a developmental disability live in poverty;

- 60% of people with a developmental disability are out of the labour force;

- estimated percentages of developmentally disabled people in Canada's criminal justice system range from 2% to 36%.

People with a dual diagnosis experience a double jeopardy effect of stigma which occurs when two disabilities, both developmental and mental health, are present in the same person.

In a 2009 study of Ontario ACT teams, of the 67 teams surveyed, 53 reported that their education needs regarding dual diagnosis were medium or high. There was also no consistency across the province in the number of people with dual diagnosis served by ACT teams.

Today, we'd like to present three issues.

Issue number one, lack of access to clinical care and specialized services: First and foremost, people with a dual diagnosis are often denied access to service. There's

limited training for both health and mental health professionals on dual diagnosis and, finally, no consistency in the availability of services province-wide.

Recommendation number one: Every Door is the Right Door must also be true for people with a dual diagnosis, and the full spectrum of mental health services must be available to them.

Recommendation number two: University curriculum for health and mental health professionals must include modules on developmental disabilities and dual diagnosis. Ongoing professional education must include workshops and seminars on the complex needs of people with dual diagnosis.

Recommendation number three: Build on the innovation of specialized care networks which have developed expertise in connecting services to one another for this population and which have training programs already available for developmental services staff so they can learn about mental health problems, and for health staff so they can learn about developmental disabilities.

Issue number two, the need for ministry-level leadership, follow-through and funding for joint policy guidelines for the provision of community mental health and developmental services for adults: (a) Ensure consistent province-wide uptake of the joint policy guidelines for the provision of community mental health and developmental services for adults with a dual diagnosis; (b) Follow-through with dual diagnosis guidelines would not be expensive, but it's naive to assume needed changes will just occur without at least some investment; (c) Many ministries must commit to working together to support this population. The Ministry of Community and Social Services and the Ministry of Health and Long-Term Care both must invest equally to try to support those with a dual diagnosis.

Recommendation number four: Ensure that the joint policy guidelines for the provision of community mental health and developmental services for adults with a dual diagnosis are implemented consistently across all 14 LHINs, along with the appropriate funding for implementation.

Recommendation number five: Coordination of services on the ground begins with coordination of the ministries that fund and produce policies and standards for them. Relevant ministries must challenge themselves to work together for the sake of the people they serve.

Recommendation number six: The Ministry of Health and Long-Term Care must match the investment in the community networks made by the Ministry of Community and Social Services. This would require an investment of \$4 million.

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Issue number three: People with a dual diagnosis are occupying expensive in-patient beds in general hospitals and in specialty psychiatric hospitals, sometimes for many years. Many of these patients do not require such high-cost services. In addition, many forensic beds are occupied inappropriately by people with a dual diagnosis.

(a) The Ministry of Health and Long-Term Care recognizes the need to move people with a dual diagnosis

to community settings, but has failed to develop an investment strategy to assist the Community Networks.

(b) People with a dual diagnosis would be better and more cost-effectively served in community settings.

Recommendation number seven: The Ministry of Health and Long-Term Care must invest in the Community Networks so that they can focus on assisting in the task of moving people with a dual diagnosis to lower-cost, higher-quality-of-life community settings.

Our final recommendation is the Ministry of Health and Long-Term Care must invest in community mental health housing and clinical supports specifically for the dually diagnosed so that these services have the capacity to accept people with dual diagnosis when they are discharged from in-patient and forensic settings.

I'd like now to ask Mark to talk a little bit about his experience.

Mr. Mark Dorsey: Thank you, Tony. My brother, Steven Dorsey, has tuberous sclerosis. It's a rare genetic disease in which benign tumours grow in the brain and other vital organs. As a result of that, my brother is developmentally delayed and he also has some behavioural problems. He also suffers from kidney disease and has numerous seizures on a daily basis.

In spite of his physical limitations, though, my brother has developed into a funny, entertaining and infectious personality. However, at one point, in his late teens, my brother's behavioural problem started to become a major issue, especially as his size grew. In large part, due to the crazy combination of behavioural drugs that he was being prescribed, Steven started getting very aggressive and would often lash out at family members and others who were close to him. Finally, my family came to the very hard decision that we needed to place Steven in a group home, not only for his own safety, but also for the safety of others.

Over the last five years, I have been a student at Guelph university. I've visited my brother in Barrie every other weekend. I was there on the day Steven was admitted into the Bayview Mental Health Centre in Penetanguishene and it was the saddest day of my life. I remember leaving almost in tears because the facility seemed like a prison. I couldn't imagine how lonely and confused my brother must have felt being there. Personally, I felt helpless.

The care that my brother received at Bayview was not very good at all, truthfully. Steven was not allowed to have any of his favourite toys at the group home. He had nobody to interact with and it seemed like the answer to almost every problem was just to sedate him. From what our family noticed, it seemed as though there were all kinds of staff that were coming out of the woodwork during fire drills and stuff like that, but, really, they didn't do much of anything for Steven other than get him off his medication.

My brother's stay at Bayview completely altered his personality. Along with picking up a lot of quirks from others, he stopped talking entirely and lost a dangerous amount of weight. It seemed like his refusal to speak was

his way of getting back at the rest of the family for abandoning him in a prison-like setting.

Of course, the goal of our family was never to have Steven stay at Bayview for such a long term. He ended up staying for so long because of the numerous hold-ups in getting Steven into Pineview treatment centre. Steven eventually did get in, much to the relief of everybody.

I remember the first time that Steven and my father and I visited Pineview to have a look at it. Aside from being a beautiful old house, Pineview also seemed to have a relaxed and friendly atmosphere. There was a giant playroom full of toys and a big screen television, which was a huge bonus for Steven since he's a big movie buff. There was a large room for Steven to move in all of his personal belongings that he had missed so much at Bayview. He was sickly skinny and completely non-verbal coming out of Bayview, but in only a short time at Pineview, he became the old Steven. Sometimes when I would go to Penetang to pick Steven up at Pineview, he would be playing under supervision and would run up to the car excited to see me. Needless to say, it was great to have Steven back.

When a group home vacancy opened up in my hometown of Barrie, Steven transitioned into a group home on Ferris Lane, where he currently lives. The transition from Pineview to his current group home was excellent, thanks in large part to the help of the director of the treatment centre, Marnie McDermott. Members of staff from Pineview brought him to his new group home a couple of times in order to make sure that he was comfortable and got adjusted properly. They've also continued to work closely with our family in Steven's care and they keep in touch with our family on a regular basis.

If I could offer a suggestion to you from my personal experiences concerning the treatment of people with developmental disabilities, it would be that there needs to be an increase in the number of rooms at Pineview, specifically. Even better would be to open up another treatment facility. The goal, in my opinion, should be to get people out of Bayview and into a proper living situation as quickly as possible. Some people are at Bayview for their entire lives, which is horrible to think about. They have very little freedom.

Having done a bit of research on the history of treatment for people with developmental disabilities, Bayview left me with the feeling that not much has changed since the days when people with a mental handicap were just institutionalized and not nurtured at all. Thankfully, Pineview and Steven's current group home in Barrie have restored my faith that there is care out there that offers people with developmental disabilities the opportunity to enjoy relationships, community excursions and other bits of normalcy that we often take for granted.

To see Steven and some others I have encountered go through Pineview Treatment Centre and end up being very successful in a group home is great. However, there are still a lot of people out there who are not being transitioned quickly enough due to a lack of facilities and funding. It's a serious issue that needs to be addressed.

Thanks for letting me talk to you today, and thanks for allowing me to give voice to people like Steven and Marc here.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for your presentation. We've probably got time for a few short questions, starting with France.

M^{me} France Gélinas: I wish I knew the facilities that you were talking about better than I do. Pineview is a treatment centre for dual diagnosis?

Mr. Tony Vipond: That's correct.

M^{me} France Gélinas: And from there, he was able to be transitioned to a group home where he now lives. When you talk about Penetang, that's when he got admitted into a hospital?

Mr. Tony Vipond: The mental health centre in Penetang.

M^{me} France Gélinas: Okay. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Anybody on this side?

Mrs. Maria Van Bommel: I'm just wondering: Would you be able to give me a sense of how many people with developmental challenges go undiagnosed when it comes to mental health in dual diagnosis, that they're just simply categorized as developmentally challenged and that's that?

Ms. Liz Froese: That's a very good question. A lot of times when people present with a behavioural issue, it could be an underlying mental health issue, so it's misdiagnosed that way, or it's a diagnosis of mental health when the underlying is behavioural. There's a debate always between health and developmental services about whether it's behavioural or mental health. So that can sometimes skew it.

Sometimes we think that the 38% where we say individuals with a developmental disability have mental health issues—sometimes we think that's underrated, because of our experience. We don't have any research to say how many go undiagnosed, but it is a question that's out in the community.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Liz. Sylvia, Christine?

Ms. Sylvia Jones: Thank you very much for appearing. You can probably answer some questions that other organizations would not be able to. I am interested to know, with dual diagnosis treatments—because you have the four nodes, northern, southern, eastern, central, you must know more than most where the system is really falling down, where there is no treatment, where the treatment has huge waiting lists. Can you enlighten us?

Ms. Liz Froese: One of our provincial priorities as community networks is clinical services. Right now, there's such a discrepancy. The north is really suffering from a lack of clinicians who have an expertise in dual diagnosis or an expertise in working with individuals who have a developmental disability. Even when they have openings for professionals, they can't recruit to the north. So what we've done with the networks is video conferencing, trying to bring clinicians in via video. It's

still not the best—face to face—but it's second best for right now.

We don't have the research dollars, but what we'd like to do is find out what best practice is, what is a good clinical service that needs to be in every community to support someone with a developmental disability and mental health issues. So we're working on that right now.

Ms. Sylvia Jones: When do you expect to have that information?

Ms. Liz Froese: That's a good question. When we have a little more resources. We're trying to partner with CAMH and with other service providers to get that research base done. So, hopefully in a year we'll have—I know it's not good enough, but with the lack of time and resources, we're doing our best with what we have.

Ms. Sylvia Jones: And I'm assuming, based on your presentation, that you are receiving no money currently from the Ministry of Health? It's all coming from community and social services?

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Ms. Liz Froese: That's correct.

The Chair (Mr. Kevin Daniel Flynn): Thank you. I just wondered, Marc Hadida, would you be prepared to answer a question?

Mr. Marc Hadida: What am I going to say?

The Chair (Mr. Kevin Daniel Flynn): I have a question for you: If you were going to live by yourself in the community, what would you need every day to do that?

Mr. Marc Hadida: At the hospitals they—I actually don't do anything. I just roam around the halls almost all day. But one of my support workers got me a workshop over at King and Spadina. I go there three days a week, half days—Mondays, Wednesdays and Fridays. Today, as you see, I am not there. That's about it.

The Chair (Mr. Kevin Daniel Flynn): Okay. Thank you very much for coming today. We really do appreciate it. Mark, Marc, Tony and Liz, thanks for presenting. Great presentation.

YOUTHLINK

The Chair (Mr. Kevin Daniel Flynn): We've had a little bit of a change in the agenda, and that is, our 4:45 is going to change places with our 4:30 appointment, so I'm going to call forward Paul Bessin from YouthLink. Welcome, Paul.

Mr. Paul Bessin: Thank you very much.

The Chair (Mr. Kevin Daniel Flynn): I'm assuming you're Paul.

Mr. Paul Bessin: I am.

The Chair (Mr. Kevin Daniel Flynn): If you'd like to introduce your colleague who's with you today. The same rules as everybody else: 15 minutes. Use it any way you see fit. If there's any time at the end, we'll have a little exchange.

Mr. Paul Bessin: Great; thank you very much. I'd like to thank the select committee members for the opportunity to speak here today. I'm Paul Bessin, the manager of counselling and family support at YouthLink in

Scarborough. Beside me is Sabina Chatterjee. She's the manager of Youth Skills Zone and the Inner City youth programs, located on Vanauley Street in downtown Toronto. I'm going to give you a very brief overview of our agency. We've provided a package for further information. Throughout our presentation, we'd like to give emphasis on the importance of prevention which serves to improve mental health in youth, prevention that gives emphasis to the importance of housing, meaningful activity, social relationships and inclusion, all of which we consider necessary for good mental health.

Our particular niche is to provide services that are responsive, flexible, and client- and community-driven, all to bridge the gap that exists because so many mental health and addiction services are currently dependent on medical and psychiatric diagnoses.

To revisit, there are three points that we want to make today, the first one being that YouthLink provides intervention that is not medical-model, diagnosis-driven; that our community-based forms of intervention produce positive outcomes and are crucial to addressing the needs of youth who have mental health concerns; and third, services and programs lack adequate ongoing core funding and are at significant risk of further erosion.

YouthLink has a long history in the city of Toronto, beginning in 1914 as the Big Sisters Association and evolving to Huntley Youth Services in the 1980s, to the present-day YouthLink. Our agency currently provides a continuum of services for young people aged 12 to 21 or to 24, depending on the service or program. The continuum consists of prevention efforts such as public education, employment and housing supports at one end, to a more intensive residential treatment program at the other end. Our prevention efforts are aimed at connecting youth and their caregivers to promote emotional and physical well-being.

Currently, we are funded by the Ministry of Children and Youth Services, the Ministry of Health and Long-Term Care, United Way, city of Toronto, and corporations such as RBC and the Counselling Foundation as well as through private donations.

In terms of who we serve, many of the youth that we're providing service to have had past involvement with other children's mental health organizations; they've had stays in child or adolescent units at hospitals across the provinces, residential programs and shelters. Some youth have long histories of being in and out of care of child protection agencies. They are typically identified as hard to serve or unmotivated. We also provide service to youth with developmental issues living with caregivers who are struggling to plan for the longer-term care of their teen or young adolescent with special needs. There is also a substantial newcomer youth population we provide service to across the city.

Young people we provide service to can be suspicious of the system of help that is available, discouraged with their past experience with and hostile toward people who want to provide assistance. Still, some are rather skilful and adept at managing to get what they need for the

immediate from the system. We're dependent on our staff to engage with these youth, to develop trusting relationships that endeavour to give youth a voice in the help that might be offered. Our assistance always centres on the youths' and caregivers' views and opinions of what might create change in their lives.

In terms of the complex system of help for children and youth, community-based prevention and intervention models or methods are as valuable and deserving of financial and policy supports as are medically driven forms of intervention. We really want to push this point forward today, the point that there are many options of assistance that our agency provides independent of diagnoses and prescription of treatment. Diagnoses must not be the only determinant for help and assistance for young people with mental health concerns. We urgently need equitable funding across the spectrum of hospital inpatient, outpatient and community-based services. We urgently need more work to remove the silos between the Ministries of Health and Long-Term Care, Children and Youth Services, and Community and Social Services. Efforts must focus on eliminating restrictions in legislation, regulations and program criteria.

Our prevention efforts are aimed at reducing family conflict, supporting youth in housing, pre-employment training, providing a harm reduction approach to substance abuse, all of which can alleviate symptoms typically attributed to mental health and prevent further risk in youth. We believe that there's a broad understanding in, and acceptance of, the value of community programs and supports to promote positive mental health; however, the programs are under considerable financial strain and lack solid public policy to ensure their sustenance.

It's a huge challenge for YouthLink and other like-minded organizations to try to provide supports across a broad range of needs for youth living at home and for the street-involved youth population. Our reliance on project-based, limited-year, patchwork funding makes it particularly difficult for our programs to fulfill their potential. As the mental health needs of youth accessing our programs increase with every year, so too do the needs for training, additional staffing and increased service partnerships.

I am now going to turn to Sabina to talk more specifically about the street youth population supported by Youth Skills Zone at Inner City programs located at Queen and Spadina.

Ms. Sabina Chatterjee: I'm really thankful for the opportunity to address the committee, and to provide some focus on a growing, multiply marginalized youth population that is faced with profound mental health and addictions challenges: the street-involved and/or homeless youth population.

Established in 1980, YouthLink's Inner City Drop-In and Resource Centre provides a broad range of support services for street-involved and/or homeless youth in Toronto's downtown core. We offer access to basic needs-based services such as access to showers and laundry facilities, food and clothing within a welcoming and non-

judgmental environment. We also provide street outreach, HIV and hep C support services, harm reduction services and information about healthy sexuality and sexually transmitted infection prevention. The intentional informality of our service provision within the drop-in program has been proven to be a very effective way to provide support for street-involved youth. In addition to those, we also have housing access and follow-up supports, including an intensive follow-up worker who works primarily with youth with more mental health challenges.

The youth who use our services are often transient, and/or very "system shy." This means that it is essential that supports provided for them need to be easily available, on-site and flexible in meeting the needs of our youth population.

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Our community partners enhance our services by providing on-site health care, legal support, mental health support, identification acquisition, and employment training and resumé building. Having easy access to these services within a space that is comfortable and inviting for street youth is crucial in helping them move from simply surviving to thriving.

In addition to basic support provision, the staffing team at Inner City is committed to providing opportunities for youth engagement that takes into consideration the wide variety of learning needs, mental health issues, cognitive disabilities and life circumstances that may be present in the lives of the youth who access our services. We have a physical recreation program that takes place twice per week and a Thursday night drop-in that provides the opportunity for arts-based programming. Informal activities and workshops are also provided on an ongoing basis within our drop-in hours of operation.

Core to our programming is our commitment to recognizing and building on the strength and resilience of youth. Our peer education program integrates former street-involved youth into the team to work in the drop-in and conduct street outreach alongside staff. The peer educators are able to share their life experiences with an aim of helping young people better use their local community support systems and deter the more vulnerable among them from becoming street-involved.

According to Youth Homelessness in Canada: The Road to Solutions, a research paper authored by Raising the Roof, there are roughly 65,000 young people homeless or living in homeless shelters throughout Canada at some time during the year. According to a study done in 2000, over 20% of youth in Canada live in poverty, 91% of single mothers under 25 live in poverty, and over 78% of aboriginal youth living off-reserve live in poverty.

Aboriginal youth are overrepresented in the street youth population, as well as being overrepresented within the child welfare system. In addition, the number of youth from different ethnocultural groups and newcomer youth who are homeless and/or street-involved has risen sharply in the past few years. It is essential that mental health and substance use services increase their cultural

competency so that they are able to meet the different needs of these populations.

There are many complex issues faced by homeless and street-involved youth: substance use and related issues; homelessness; income inequality; generational abuse; generational poverty; malnutrition; physical, sexual and emotional abuse; youth violence; disengagement from the education system; and sexual health issues.

Many youth who are street-involved have experienced some form of mental illness and substance use. In our experience, the youth who are currently accessing our support services seem to be living and coping with mental health issues that profoundly affect their ability to participate in traditional programming for youth. Even the scope of support provision that we can provide can be dramatically affected by the needs of these youth. The goal-oriented support provision for some cannot focus on housing or employment or education, but rather on basic survival such as eating, wearing shoes in the winter, re-learning how to use a washing machine or having showers.

At YouthLink, we assist youth in accessing the external supports they need. However, this is not without its own challenges. Youth who live with mental health issues and use substances are still told more often than not by mainstream providers that they need to deal with the substance use or the mental health issue. There is such a strong need for support within a concurrent disorders framework, as well as advocacy for the mental health system to be more open to working with youth who may be in crisis in addition to, or because of, their possible substance use.

Just yesterday, we had a young man who self-identified as being in a manic state, with seriously diminished impulse control and near-hysterical laughter, who was expressing his concern over his own safety. He told a staff person that he was worried that if he went home he would throw himself repeatedly against the wall, because, in that moment, it would feel like the right thing to do. The staff member spent a great deal of time trying to connect him with a mental health support program and needed to advocate for the youth to be taken seriously, as the other service provider reacted to the youth's laughter by saying, "Are you sure he hasn't just been using?" Eventually the other service provider agreed to meet with the young man.

We believe that it is very important to work within a harm reduction framework within both Youth Skills Zone and Inner City. We believe that by providing support within that framework, youth who are living with both mental health concerns and substance use issues are able to feel comfortable within our service provision and are able to begin to get the crucial support they need.

Just to underline that, in the last six months, we've had four youth die of suicide and/or overdoses. So there is such an ongoing challenge for us. It becomes really important. These folks are so dislocated from other systems of support that we need to keep on trying to create more options.

So to conclude, we'd like to reiterate the importance of recognizing and supporting the real value of community-based support services such as YouthLink, which provide services for the most multiply marginalized youth in our communities. The pressures of trying to do this very important work within a funding environment of instability and the reliance on project-based, limited-time funding make long-term strategic planning and service delivery very challenging. Our dedication to utilizing trauma-informed, intentionally informal support services for street-involved youth needs to be supported, because providing these services for youth can save their lives.

The Chair (Mr. Kevin Daniel Flynn): Thank you. You've left about a minute for questions. Can we have one quick one, Helena?

Ms. Helena Jaczek: Yes. Thank you both for coming. It's a question for Paul. You have a statement here on page 2: "Efforts must focus on eliminating restrictions in legislation, regulations and program criteria." Could you just give us a couple of examples?

Mr. Paul Bessin: Well, I'm glad to have fallen on the heels of your other presenter, from Peel, who was talking about the fact that there are some programs that limit the age up until 18 when they're funded through the Ministry of Children and Youth Services. We see a lot of transitionally aged youth.

I want to underscore and reiterate the point that she made, that was well articulated, about the fact that there are more young people who are staying at home, who have complex needs, and for them to navigate, to go from youth- or child-focused services into the adult, there's a huge gap there. That's one of the things that I'm making reference to there.

I hope that answered your question.

The Chair (Mr. Kevin Daniel Flynn): Thank you, and thank you very much for appearing before us today. Great presentation. I think you got your point across very clearly.

Mr. Paul Bessin: Thank you very much.

ONTARIO PUBLIC SERVICE EMPLOYEES UNION

The Chair (Mr. Kevin Daniel Flynn): As a result of the change in our agenda, our next presenters are from the Ontario Public Service Employees Union, Patty Rout and Sheryl Ferguson. Make yourselves at home. There should be some clean glasses and some water there. Like everybody else, you get 15 minutes. Use that any way you see fit. If there's any time left over at the end, we'll just split it amongst the groups. We're all yours.

Ms. Patty Rout: Thank you very much for granting OPSEU this opportunity to address your committee. I'm Patty Rout, first vice-president and treasurer of OPSEU. That's the Ontario Public Service Employees Union.

With me is Sheryl Ferguson, the chair of our OPSEU mental health divisional executive and president of

OPSEU Local 431, which is Providence Continuing Care Centre, Kingston.

You have our submission before you. We represent about 130,000 members within OPSEU. Some of those members are nurses—many of them, actually, are nurses—psychologists, psychometrists, social workers, youth care workers and support staff, all of them having an effect on mental illness and addictions, and we hope that we're strengthening the lives of the people who are there.

Our members also are the support staff and faculty members who teach many of the programs in the community colleges. As well, we have corrections staff, who also deal with mental health issues through the judicial system.

Your consultation paper, Every Door is the Right Door: Towards a 10-Year Mental Health and Addictions Strategy, has the potential to affect many of our members, so we're really welcoming this opportunity to be involved with the consultation process.

OPSEU agrees with the proposed approach to integrate people with mental illnesses and/or addictions into their communities. However, the integration of mental health and addiction services with the rest of the health system and other pertinent sectors is worrisome.

I must say that integration, in my world, in my experience, usually is translated as meaning cuts to important programs and services.

Despite the latest effort to reform the mental health and addictions strategy for Ontarians for the next 10 years, the provincial government has again failed to properly address multiple core issues related to the provision of quality mental health care.

OPSEU has reiterated the same issues over the course of decades, yet we always appear to come full circle on these problems. In short, OPSEU strongly disagrees with the methodology used in the Caplan report. Although its goals are attainable, the current funding model must be re-evaluated to ensure the services and programs are properly resourced.

Our formula to get the plan right involves the following: Recognizing the importance of psychiatric hospitals, while providing proper resources for patients with mental illness and/or addictions. This would include the fast and efficient delivery of programs and services such as children's mental health, healthy communities, and the need to ensure a viable, well-resourced workforce.

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Increasing funding: Part of the proposed strategy, which focuses on early intervention, identifies a number of key players to assist in creating public awareness. This involves the affected individuals as well as the people in their communities. Although the concept of early intervention through education is logically sound, there are many practical flaws in the proposed strategy. It is commendable to want all workers in related fields to be fully trained, but much more is required to turn that vision into reality. The main issue is sufficient funding for each public sector caring for those people with mental illness or an addiction.

Given the continual lack of funding seen in Ontario for mental health and addiction over the years, this goal seems destined to remain a dream. For example, Ontario is cited as having one of the lowest public per capita mental health expenditures compared to the rest of Canada. The national average is about \$172 per person, whereas Ontario's is \$152 per person. British Columbia's spending is the highest, at \$230 per person. According to the OECD, Canada has one of the lowest rates of mental health spending relative to health spending of all other OECD countries.

Children's mental health services continue to see an all-time low level in funding. They are most vulnerable to cuts to programs and services since they are a non-mandated service under the Ministry of Children and Youth Services, yet child treatment continues to play an important role in mental health and addictions. They provide early intervention, which Caplan cites as being a core component in providing seamless care.

It is important to note that since 1993, the funding of core budgets has increased by only 8%, yet there has been a 30% increase in the cost of living in that same time. To be clear, there needs to be more funding for specialized services such as mental health and addictions, including guaranteed core funding for children's mental health services. This is critical for the future of mental health and addictions in Ontario for all ages. Implementing such an ambitious strategy will require stable funding from year to year to ensure that the relationships can be built, strengthened and sustained.

It is very important for all Ontarians to have access to the same services, as Caplan stated. But where is the assurance that all Ontarians will have access to the same service when there are continued closures of mental health facilities across Ontario? Most recently, the Brockville Mental Health Centre is scheduled to close in March. Individuals with mental illness and addiction will be forced to travel to the Royal Ottawa Hospital from Brockville. This is particularly disturbing given the importance geography plays for individuals when they're trying to access mental health services.

An even more recent example is the threat of reducing the problem gambling treatment program at Lakeridge Health in Oshawa. Even though the program is well utilized, the Central East LHIN is still threatened with hospital cuts—\$3.4 million. The proposed plan is to reduce the number of beds from 20 to 11 and only allow people within the Oshawa area to access the program. This program is a prime example of a valuable program funded from a hospital global budget which is at high risk for closure despite the need in the community. Unfortunately, HAPS has suggested that hospitals under pressure should just eliminate mental health and addiction services funded in this manner without even looking to see if the service is an asset in the community.

Having viable programs and services is critical, but so, too, is accessibility. As with physical health concerns, programs and services must be available to all individuals with mental illness and/or addictions. Therefore, it is

absurd to be closing facilities and reducing the capacity of well-utilized and needed programs.

Increase the capacity by using resources differently and more efficiently: The Caplan report states that there is a belief that capacity will increase by using resources differently and more efficiently. Does this translate into using the same resources, which we have already established as insufficient, to support even more programs and services? Since 1993, the number of children in Ontario requiring mental health services has doubled to over 200,000 children. It has been reported that five out of every six children who require specialized help are not receiving care, and that those who do face an average wait time of five and a half months. This speaks volumes about the need for core funding as opposed to the need to use resources more efficiently, as stated in the Caplan report. The Deloitte report, 2006, states that there have been delays in the discharge of patients with mental illness and/or addictions from hospitals due to the lack of resources in the community, not the misuse of the resources.

Healthy communities feature education, jobs, income and affordable housing. OPSEU agrees that education, employment opportunity, income and affordable housing are the basic building blocks to ensure the stability and well-being of individuals with mental illness and/or addictions. But this isn't new, and where we continue to get bogged down is the lack of commitment towards these goals. These aims cannot be achieved by simply shuffling existing resources. How are individuals with mental illness and/or addictions going to be able to afford to stay in school and have appropriate housing and food when the levels for ODSP are at an all-time low in relation to inflation? Presently, the ODSP level for a single person is approximately \$1,000 per month. The average bachelor apartment in Toronto is about \$700 and food costs \$200 per month. That leaves \$3 a day for other expenses, such as clothing, transportation, telephone and other needs, and if they want to take a part-time job to be able to manage, they end up having to give up 50 cents on every dollar from their ODSP cheque. How can these individuals thrive or ever get ahead with such crushing limitations?

OPSEU members know through decades of front-line care that the failure by the province to seriously address poverty is a failure to seriously address mental health and addictions. In our workforce, the Caplan report acknowledges, there are shortages of skilled mental health and addiction workers across Ontario, which, in turn, has contributed to your wait lists, job stress and burnout. To improve the crucial recruitment and retention issue, Caplan suggests addressing stigma associated with work and the lack of opportunity for professional development. While we agree that these are relevant concerns, OPSEU believes that the underlying issue remains the inability for people to get full-time employment and the inability to deal with workload concerns.

Several studies, as detailed in our brief, reveal that many new graduates are leaving the health profession

within two years of graduating. This is not surprising, considering the increased workload created by countless divestments and hospital closures. It is no wonder that workers are feeling overworked and stressed. These individuals are asked to do more with less, so they are leaving the profession early or they're forgoing it altogether. We believe the solution to these problems must be multifaceted. Any solution must include increased and guaranteed funding and effective, regular consultation with our members.

In conclusion, many issues have been brought forth by the Caplan report on how to improve mental health and addictions. OPSEU is convinced that in order for Caplan's suggested strategies to be effective, there must be a dedicated plan that can solve the persistent problems of appropriate and secure core funding, including children's mental health, cutbacks to valuable programs and services, the closure of psychiatric facilities and the unstable workforce. These issues are complex and require extensive further discussion. We believe that the government is in a position to implement the necessary changes to make every door the right door. Thank you.

The Chair (Mr. Kevin Daniel Flynn): That's great, Patty and Sheryl. Thank you. You've probably left time for one very brief question. Christine or Sylvia? We've got less than a minute.

Mrs. Christine Elliott: I don't really have a question, more a comment. Thank you very much for coming. It's great to see you again.

I just wanted to mention to you that you know that we're not the authors of the Every Door is the Right Door paper, and I think the important distinction is that we are looking across the broad spectrum at a variety of ministries. So the comments that you're making regarding ODSF issues and so on are very relevant to this committee, and we certainly are taking those into consideration as we formulate our recommendations. I just wanted to reassure you that we are taking all of that into our recommendations for the future.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Patty and Sheryl, for coming today.

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CHILDREN'S MENTAL HEALTH ONTARIO

The Chair (Mr. Kevin Daniel Flynn): Our next presenter this afternoon is Camille Quenneville from the Children's Mental Health Ontario organization, if you'd like to come forward. Good to see you again. Maybe you can introduce your colleague.

Ms. Camille Quenneville: I think he's going to introduce me.

The Chair (Mr. Kevin Daniel Flynn): Oh, really?

Mr. Gordon Floyd: We've got it turned around a little bit.

The Chair (Mr. Kevin Daniel Flynn): Okay. If you'd introduce yourself, then, so that Hansard knows who you are. Same rules as everybody else: 15 minutes.

Use it any way you see fit; if there is any time at the end, we'll share that among the groups. Thanks for coming.

Mr. Gordon Floyd: Thanks very much, Mr. Chairman and members of the committee.

My name is Gordon Floyd. I'm the president of Children's Mental Health Ontario. I'm joined by Camille Quenneville, who's our director of policy and communications. In her spare time, Camille is a volunteer with St. Jude Community Homes here in downtown Toronto, where she serves as chair of the board. She's going to briefly tell you about St. Jude's when my remarks conclude.

I know you've travelled the province, heard countless presentations and read a pile of briefs, so I plan to speak briefly today to allow ample time for a bit of dialogue with you before our time runs out.

Just by way of background, Children's Mental Health Ontario represents 87 community-based agencies that provide support to families and young people. They collectively account for about two thirds of this government's annual expenditure of approximately \$500 million for child and family intervention. They treat a range of social, emotional and behavioural problems including bullying, violence, ADHD, eating disorders, depression, self-harm, anxiety, addictions and more.

There are three important areas I want to touch on and then I'll answer your questions. They are, first, the urgency of system reform; secondly, the need to maintain services until reform happens; and finally, the opportunity to focus scarce dollars where they will have the greatest impact.

First, it is critically important for our sector to have the policy framework for children's mental health, A Shared Responsibility, implemented quickly and efficiently. We are full participants with the ministry in this exercise. We believe the sector has to change and that much of the change is happening or will happen within the sector. We also believe that stable funding to provide an appropriate level of service to every child and youth needing mental health support will hinge on the implementation of this framework. You may recall, when I addressed you in June, that I pressed hard for progress to be made on implementation. I want to acknowledge that much has happened since then and we're pleased to have the mapping process moving along so that we all can know more about where services and gaps in service exist. We look forward to the next concrete steps from the Ministry of Children and Youth Services. At the same time, we'll be working with the Ministry of Health and Long-Term Care to encourage them to renew work on their paper Every Door is the Right Door.

The second topic I want to touch on is that during times of recession or economic slowdown, you're no doubt aware that the need for mental health supports increases. This is true in both the adult and the child and youth mental health systems. The impact on our sector has been immense. The effectiveness of mental health treatment depends first and foremost on the quality and skill of our front-line staff, yet we are steadily losing

well-trained, dedicated staff to other sectors, such as health and education, where the compensation is considerably better—25% to 40%, depending on the community. We work closely with sectors that receive annual funding increases from this government, yet our sector has had only two increases in the past 12 years, both of them only inflationary. While the policy framework is being implemented, we're simply asking for a level playing field with the other services this government funds so that our vulnerable children and youth can be served by the most qualified, the very best staff.

The third topic I want to touch on: In a time of fiscal restraint, it's more important than ever to be strategic in setting priorities and in focusing available funding. Although I realize your mandate covers the lifespan, I would remind you that 70% of all mental health problems first emerge during childhood. That's also when we have the best opportunity for successful treatment. Placing a higher priority on the mental health needs of children and youth will yield benefits both by ensuring we have a productive workforce in the future and by reducing demand for government services of many kinds, especially lifelong mental health services.

It's also critical, especially when dollars are tight, to ensure that they are focused for optimal outcomes. In the field of child and youth mental health, funding is now scattered across 440 transfer payment agencies. Compare that with only 53 agencies that handle all child protection services across Ontario. Consolidating existing dollars in agencies that have the capacity to deliver evidence-based practices and that meet basic quality standards only makes sense. We suggest that only agencies that can meet objective and independently administered accreditation standards should be eligible to receive child and youth mental health funding. To that end, we are currently transferring our in-house accreditation program to an independent agency so that it will have the necessary credibility to become a funding requirement.

As you might imagine, I could go on at great length about the families, children and youth our agencies support. You've heard some of that from our members today and in your hearings across the province. I'm going to resist the temptation to do more, but I will leave you with a sincere thank you for the time, energy and compassion with which you are tackling the issues of mental health and addictions. We're all looking forward to your final report. Now I'll pass it over to Camille for some brief comments about St. Jude Community Homes.

Ms. Marie Quenneville: Hi, everyone. St. Jude Community Homes, which is located in Regent Park in Toronto, was formed in 1986 by a group of very committed citizens who were increasingly concerned about the homeless problem in this city. Today there are three buildings providing supportive housing to 87 adult residents who live with severe and persistent mental health problems. About 95% of our residents have been diagnosed with schizophrenia. All residents are dependent on ODSP and, in some cases, CPP disability.

Our motto at St. Jude's is "Together in community, we succeed," and it's evident the moment you walk through

the doors. Everything we do at St. Jude's fosters that sense of community and the respect and compassion our residents show for one another.

The food program is significant in that regard. Residents pay a monthly stipend which covers both a healthy breakfast and dinner, which is prepared on site. Residents have kitchen facilities in each of their units where they have lunch. Enjoying meals together is critically important for anyone with a mental health issue, as I'm sure you know, to allow a sense of belonging and fellowship. There are activities for our residents and employment supports if their health allows.

As you might guess, the staff at St. Jude's is extraordinary, and we're fortunate to have a psychiatrist from CAMH on our board. When we asked him why he was interested in serving at St. Jude's, he put it simply: He said that he knows that when he refers clients to St. Jude's, he is sending them to the gold standard for supportive housing.

If any of you are interested in your copious spare time, which I know you all have, I would love to shuttle you over to St. Jude's—it's very nearby—and give you a very quick tour. I think we're a model for compassionate treatment of some of our most vulnerable citizens.

The Chair (Mr. Kevin Daniel Flynn): That's wonderful. Thank you, Gordon; thank you, Camille. You've left ample time for questions, starting with France.

M^{me} France Gélinas: I have many points to my question. The first one I want to ask is, we had other presenters talking about children's mental health who talked about the transition period between child and adult mental health, and some of them asking for funding for their service to be available up to age 24. I would like you to comment on that first.

Mr. Gordon Floyd: There is a well-acknowledged problem: a gap in services. When kids reach the age of 18 they kind of fall off the map and are not usually well served by the adult mental health system; they're no longer eligible for service in the children's system. There is clearly a need for the two systems to meet in a much better way. What's going to be appropriate is going to differ from client to client. I think that there is a need for children's mental health agencies to be able to offer services beyond the age of 18, perhaps all the way to 24, just as there is a need for adult mental health services to reach out in a more effective way to young adults. I think that it would be very helpful and very important for children's mental health agencies to have the option of being able to continue service beyond the age of 18.

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The Chair (Mr. Kevin Daniel Flynn): A short one.

M^{me} France Gélinas: We've heard many times that children's mental health is the poor cousin of mental health, which is the poor cousin of health care. Has your association ever quantified that? And of the 440 transfer payment agencies for children's mental health that presently exist, where would you see a reasonable number fall at?

Mr. Gordon Floyd: In terms of your first question, we haven't quantified it in dollar terms but perhaps one

of the best ways to look at it is when you look at wait times. The wait times in the children's mental health system are significantly longer. Most indications would be that they're about half again as long as wait times in the adult mental health system.

Another benchmark would be that the average wait time to get into a children's mental health centre in Ontario is almost exactly twice what the average wait time is for general pediatric surgery.

So we do have a big gap between the way children with mental health problems are treated as compared to the way children with physical health problems are treated. I think the same is undoubtedly true in terms of the gap between child and adult services.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Gordon. We're going to move on. Jeff?

Mr. Jeff Leal: Thanks so much, and thanks so much for your presentation today. Camille and I are friends, so I'll take you up on your offer to come and visit St. Jude. I'd love to do that at the first available opportunity.

A couple of questions, Mr. Floyd. You talked in your presentation today about identifying these mental health difficulties as early as possible. I take it you would be a very big supporter of full-day kindergarten in the province of Ontario, to identify problems early.

Mr. Gordon Floyd: Yes.

Mr. Jeff Leal: My second question to you is, are there just too many agencies fragmenting service to children in the province of Ontario?

Mr. Gordon Floyd: Yes. The 440 agencies that are receiving child and family intervention funding now are about twice as many agencies as were receiving funding 10 or 12 years ago.

If you talk to people within the regional offices of the ministry, if you get them to talk off the record, they will admit that the child and family intervention budget has become a little bit of a discretionary budget within the regional office—it has been used to fill holes—and that an awful lot of the services that are being funded through that budget are not strictly mental health services. They're certainly not services that are being evaluated in any way. They're not services that are being supported through evidence-based practice in any way.

We're really concerned that a significant part—it could be as much as a third of that budget—is bleeding into services that are not appropriately accountable and are probably not as effective as they need to be.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Gordon. We're going to move on. Sylvia?

Ms. Sylvia Jones: Good to see you again. I wanted to follow up on the St. Jude example that you've highlighted. You have 87 adult residents currently; three buildings. Where did the incubation funding for that come from? How did you begin?

Ms. Camille Quenneville: Back in the day, when this group of citizens became concerned, they just took a flyer and applied for funding from, at the time, Canada Mortgage and Housing Corp., which was doling out grants, and much to their surprise, they got one.

They went looking for a place to spend the money. They found a commercial building at the corner of Dundas and Parliament and retrofitted that building for apartment-sized spaces for the residents. We've subsequently grown and added two buildings.

It's a fantastic mix of partnership between the federal government, in that sense, although they have admittedly a smaller role now, the city of Toronto, and of course the province, through the Ministry of Health.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Camille. Thank you, Gordon. Thank you very much for coming today. It was appreciated.

Our next presentation today was anticipated to come from the Bethany Residence, but I understand that that gentleman may have been held up. Is that right?

Interjection: Yes.

The Chair (Mr. Kevin Daniel Flynn): Okay, then we'll move ahead to the next group and come back to you.

YORK CENTRE FOR CHILDREN, YOUTH AND FAMILIES

The Chair (Mr. Kevin Daniel Flynn): The folks from the York Centre for Children, Youth and Families have kindly agreed to come forward. Make yourselves at home.

Interjection: Nobody's been seated down here yet. This poor chair is lonely.

The Chair (Mr. Kevin Daniel Flynn): That's the one with the ejection seat if we don't like what you say.

Interjection: You want to put me there, then, for sure.

The Chair (Mr. Kevin Daniel Flynn): Like everybody else, you get 15 minutes. You use that any way you see fit. If there's any time at the end, we'll have a little exchange.

Ms. Noreen Lee: Thank you, Mr. Chairman. I'm Noreen Lee. I'm chair of the board of directors for the York Centre for Children, Youth and Families. My co-presenter today is Donna Massel, mother of a remarkable young man who has become the junior ambassador for York Centre. We appreciate the opportunity to present the following challenges and solutions to the crisis in children's mental health services. These were collaboratively identified by Blue Hills, Kinark and York Centre, the three accredited children's mental health agencies that are currently providing services in York region.

As you've heard before, the greatest and most daunting challenge is inadequate funding. There have been no increases to our base budgets for 13 of the past 15 years. The problem in York region, which is where we provide services, has been exacerbated by a historical disparity in funding in children's services. Assessing the Gap, a 2008 update report, shows that in York region, the funding for children's services was \$127 per capita, whereas the provincial average was \$221, almost twice as much.

Decades of severe underfunding have caused erosion of services, long wait times, high staff turnover and loss of expertise because salaries are not competitive with

similar positions in health and education. The most devastating effect of lack of resources is the ongoing pain of young people struggling with untreated mental illnesses. Their excruciating experience is beyond description. You have to feel their pain as they tell their stories in order to understand the completely undermining force of mental illness.

Investment in children's mental health services not only addresses the urgent needs of children; it's also cost-effective on the part of the government. Treatment, especially early intervention, is effective, and Donna will attest to this in a couple of minutes. It significantly reduces the need for more expensive and long-term support such as youth detention and ongoing psychiatric care. Lost productivity attributable to mental illness in Ontario ranges in the billions of dollars annually.

The following demographic factors create a higher-than-provincial-average need in York region for children's mental health services:

—22% of York region residents are between the ages of zero and 14 years of age. That's much higher than the provincial average of 13.6%.

—Poverty is one of the social determinants of mental health problems. The 10% of children who live in poverty are at much greater risk.

York region has the third-highest number of recent immigrants in the GTA and is home to 204 ethnic groups. This presents the enormous challenge of providing culturally competent mental health services.

The solution to addressing the current and increasing demand for service in York region is the application of a population needs-based funding formula.

1730

Mental health promotion, early identification and intervention are critical components of a more effective and efficient children's mental health service. The challenge is that additional staff and funding for evidence-based training will be required. In addition, it will be necessary to enhance the competencies of workforces in health, education, justice and social services to enable them to identify the early signs and symptoms of children's mental health issues and to intervene appropriately.

York region is recognized as being a leader in collaborative integrated planning. Our COMPASS initiative is a respected example of the development of partnerships between child-serving agencies and school boards. COMPASS has done excellent work helping schools identify the mental health needs of children. However, because of lack of treatment resources, once they get to our doors, they discover an extremely overcrowded waiting room.

The mental health of children must be the highest priority in the 10-year strategy for mental health and addiction. This position is clearly supported by Michael Kirby's shocking statement that "Children's mental health services are the most neglected piece of the Canadian health care system." It would be unconscionable to allow the urgent needs of children and youth to be

neglected for another 10 years, unconscionable to deny young people with mental illness the right to the treatment which would enable them to experience optimal mental health and to reach their full potential.

As the current economic crisis recedes, so must the crisis in children's mental health.

Thank you for your attention and for the good work you do.

Ms. Donna Massel: Hi. They made me write my speech down, because otherwise I could go on for hours.

When my son Matthew entered school, he was a very sociable, confident—

The Chair (Mr. Kevin Daniel Flynn): Just so you know, you've got about seven minutes, so don't feel compelled to rush through it.

Ms. Donna Massel: Okay, thank you.

When he started school, he was a very sociable, confident little boy. But before he finished grade 1, his self-esteem had plummeted. He considered himself the stupidest kid in the class—his words. We were having trouble finding activities that he could be successful at, and he didn't have a lot of friends. I was having no luck at getting the school to diagnose why he was not succeeding at school. I was told that the waiting lists to see psychologists were too long and that his problems weren't severe enough.

We were on our own, so we searched out doctors to help us. We spent thousands of dollars for educational and psychological assessments. Finally, by the middle of grade 5, we had a good handle on what was causing Matthew's challenges. We had a son who had an alphabet soup of labels but who did not fit into the traditional school system, especially because he was extremely bright. I was constantly advocating on his behalf. "Advocating": Isn't that a nice word? It sure didn't feel nice, because I felt like I was always battling to get my child the accommodations and help he needed and was legally entitled to.

Grade 7 started our two years in hell. Matthew couldn't take it anymore. Depression, anxiety and rage became huge problems. In grade 7 and again in grade 8, Matthew was out of school more than he was in. He suffered breakdowns and went into crisis both years. I had a child who was depressed, anxious and really didn't think life was worth living anymore. At night he used to cry in his room and beg us to kill him because he couldn't take it anymore.

The staff at the elementary school was not able to help him reintegrate into the school system. School officials refused my requests for him to see school psychologists, but they did offer to send out the truant officer. What a huge difference it would have made if the school staff had been able to understand his challenges.

Matthew was shuffled from school to school, going to five schools in four years. We kept hoping we could find someone with the training to help him. Finally, after consultation with a special-ed superintendent, I realized something had to change. The superintendent's team and Matthew's psychiatrist recommended York Centre for Children, Youth and Families.

When Matthew started at York Centre for his grade 9 year—grade 9 we're talking about now, from kindergarten—I felt like a huge weight had been lifted from my shoulders. I wasn't alone anymore. Matthew was in a place where the staff was trained, willing and able to help him. He's flourished at York Centre. His pediatrician and his psychiatrist are both amazed at the difference in Matthew. I don't think they see too many success stories like his.

Some of you have met my son. Some of you heard him speak two weeks ago at the celebration here for the 20th anniversary of the United Nations Convention on the Rights of the Child—that's a mouthful. He made a speech on why the government should spend more money to help children like him. He was the tall, blond boy that Andrea Horwath mentioned on the floor, and he stuck his tongue out at her when she mentioned his name—nothing to do with her; it's just his reaction to hearing his name mentioned. I was very proud of him that day—not for sticking his tongue out, but because of the excellent speech that he did and how well he prepared it. Let me tell you, two years ago, he could not have even been in that room, let alone made a speech.

I would like to remind you of a couple of things that Matthew mentioned: One in five children deal with mental illness; of those, only one in five will get help. Matthew is very grateful that he was one of those who got help and he feels very badly that four out of five children that need help do not get it. Matthew ended his speech that day by saying, "If it weren't for the staff at York Centre, my doctors and my parents, I would not be in front of you today ... I would be on the floor screaming my butt off." Well, I agree with him a bit, except he wouldn't be on the floor. If Matthew hadn't gotten the help he needed, Matthew's only option would have been suicide.

Intervention at York Centre saved Matthew—it saved our family. Earlier intervention in grade school would have prevented the need for him to go away from his friends for day treatment. Matthew had a supportive family—emotionally and financially. We are so grateful for the help we received. For that reason, Matthew and I are willing to speak out about our experiences. I am told that hundreds of thousands of families deal with children's mental illness. What happens to those who can't afford thousands of dollars of private testing? How do you balance the need to work with the need to be on 24-hour call for your child? Supposedly, we don't have a two-tiered health care system, and maybe we don't when it comes to medical disabilities, but we certainly do when it comes to mental health disorders.

Matthew's story is not finished. He's in grade 10. Right now, he goes to his home high school in the morning and York Centre in the afternoon. It's been a great way for him to transition. He's currently being served at the high school in the autism class. It's not ideal for him because he's not with his peer group, academically or socially, but we are very grateful for the wonderful staff support that such a program provides.

We worry about the future for Matthew. How will he cope in high school when he tries to go back into the mainstream program? What will happen to him when he turns 18? I have been told by other parents that the transition is very difficult. If my son gets the support that he needs, then he could do great things in this world. He wants to be a doctor. If not, he could be a drain on society. Multiply my child by the hundreds of thousands of other children who, if they can get the help they need, can go on to be productive citizens—teachers, policemen, health care professionals, maybe even politicians—or they can sit on welfare rolls, in jails, on the streets or in the grave. It's your choice.

The Chair (Mr. Kevin Daniel Flynn): That's wonderful. Thank you very much for your presentation.

Ms. Donna Massel: See, that's why they were worried I was going to be too long.

The Chair (Mr. Kevin Daniel Flynn): No, you just about hit the nail right on the head there. Unfortunately, there's no time for any questions, but your story was very compelling, and I'm sure I can speak on behalf of the other members of the committee and extend our best to Matthew as well. It was like he was here today as well.

Ms. Donna Massel: Well, if the rest of you haven't heard his speech and are interested in hearing it, they taped it at the advocate's office. I'm sure we could get a copy of it.

Ms. Noreen Lee: There's a copy in the package.

Ms. Donna Massel: Oh, and also, the copy of his speech is in the package.

The Chair (Mr. Kevin Daniel Flynn): It's attached to the package, yes.

Thank you very much for coming today. It was appreciated.

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BETHANY RESIDENCE

The Chair (Mr. Kevin Daniel Flynn): Our next presenters are from the Bethany Residence: Peter Turner, Kevin Abraham and somebody who will be introduced.

Ms. Sheri Levy-Abraham: Sheri Levy-Abraham.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Make yourselves comfortable. You've got 15 minutes, like everybody else, and you can use that any way you see fit. If there's any time at the end, we'll split that amongst the groups. We're all yours.

Dr. Peter Turner: Thank you. My name is Dr. Peter Turner. Just allow me one second here to set up my slides while I talk. Originally this was supposed to be a PowerPoint presentation, but I guess we were not able to set it up as such so I'm going to just give a talk based on the handout. I'm going to read it off the computer because the slides here are a little more readable for me.

The Bethany residential care program is a program that's located in Burlington, Ontario, just up the road from here. It's a large community facility that was originally funded as a domiciliary hostel. It specializes in

the community management of severe psychiatric and chronic psychiatric disorders.

The second slide in the PowerPoint presentation: That's my introduction. I'm Dr. Peter Turner. I'm a psychiatrist. I've worked in Burlington since 1977. I'm also affiliated with McMaster University Medical Centre as assistant professor. I consult to the Joseph Brant Memorial Hospital, which is in Burlington, as a consultant to the first-episode psychosis program. I also consult with the North Halton mental health community clinic, which has a large number of chronic-care psychiatric patients. At Brant hospital, I also consulted on and set up originally a case management program, so-called, which is still in existence today. Since 1984, I've been involved in setting up work rehabilitation programs related to my special interest in schizophrenia. I've been a consultant to the Bethany residential care program, which I'm talking about today particularly, since about 1989, approximately.

The presentation objectives are to understand a little bit about the chronic psychiatric illnesses that we face in the community, and how to handle these, and what impact those disorders have in terms of the types of help we have to provide for these clients; and to demonstrate that the Bethany residential program is an important part of the regional services in the Burlington and Halton area.

The Bethany residential program has saved the province significant amounts of money over time, related to the care of clients with severe psychiatric illness. It needs your continued support and upgraded funding to maintain the quality of its clinical and support services and rehabilitation programs.

There is potential for other programs to improve the quality of care further, and potentially save money within the community and hospital budgets.

The next slide has to do with the challenges in the treatment of schizophrenia. We skip along, just to review the clinical course of schizophrenia, basically just to indicate that schizophrenia is not a one-time condition. It's a condition that persists over time and has significant residual disability associated with it and requires ongoing support. Many clients require residential ongoing support, not just outpatient psychiatry care or case management or PACT programs, which we have as well. Although the condition does get more stable over time, that remains as true today as it was historically. Residences like the Bethany program could be very important in maintaining or providing that kind of care.

The other thing to know about schizophrenic illness is that it's associated with multiple other conditions, both medical and psychiatric. These clients have all kinds of other comorbidities, like anxiety disorders and depression. They have increased cardiovascular and diabetes disorders. Substance abuse is a big issue. These comorbidities increase the risk of relapse. These people require an extensive support system, and they're frequent visitors in the hospital unless you take greater care to look after these people adequately.

The next slide again demonstrates the psychiatric comorbidities, life comorbidities, as high as 50% in various types of disorders, including anxiety, depression, substance abuse and so on for patients with schizophrenia.

The risk of medical illness is somewhere around 1.5 times to two times for obesity, twice for diabetes and five times for lipid disorders. They're also very frequently heavy smokers. Medical factors are a big issue.

Similarly, bipolar disorders are also often more chronic than people realize. The reason for that is that while they are more intermittent, bipolar disorders keep on recurring and often get more severe as time goes by. You end up requiring an extensive support system for those clients as well.

To look at the next slide, time spent in specific bipolar disorder affective symptoms: What people don't often realize is that patients with bipolar disorder are frequently mostly depressed, about 30% or so for bipolar I, which is the patients who have manic symptoms, and 50% or so for bipolar II patients, who follow more of a recurrent depression pattern. That is illustrated in the slide just before.

Again, these people need extensive and prolonged support. They also have again, as with schizophrenia, multiple comorbidities. That is a multi-dimensionality of mood disorder, which is your next slide. Substance abuse is often common, as are multiple medical disorders and psychiatric comorbidities.

The impact of bipolar disorders on patients' lives is that their health is reduced by a decade or so, and employment, of course, and marital and personal problems are much more frequent.

Moving on to the mental illness statistics and the challenges that we face: When we look in the Hamilton area, when I came in 1973 to this area to do postgraduate psychiatry, they had still the Barton building, which is part of that picture of the old Hamilton Psychiatric Hospital, which housed over 1,000 patients. Originally the whole Hamilton psychiatry hospital complex had at least 1,500 patients or better. That's been gradually whittled down in the last 30 or 40 years. Where have these patients gone? A lot of these patients have gone to community treatment centres, including places like Bethany. Homes for Special Care is another. There's a lot of those in Hamilton.

The funding for Bethany in particular has been very low. It used to be at \$47.75 per day, which is less than a motel. I think it's important to point out that it's generally underfunded to provide the quality of service that we would like to see for those clients, especially as they have multiple psychiatric and medical issues and all kinds of rehabilitation needs.

The overall national economic costs of mental illness are huge, compared to other medical conditions. Mental disorders cost about \$14 billion annually, and it's very important that they provide the optimum care and support for those disorders.

Homelessness is a common complication of psychiatric disorders. Again, 25% to 50% of homeless people have schizophrenia or some sort of severe mental illness.

In the Burlington catchment region, which is the next slide, if you look at severe mental disorders, which is our main focus here, at least 1,700 people, or about 0.85% of the population would be classified by a statistical analysis based on the projections on the American national plan for the mentally ill survey as having incidents of severe mental illness overall, which particularly includes schizophrenia and bipolar disorders. That would be the number of people who require help in our region for the most severe disorders. Lifetime prevalence of schizophrenia is about 1% but because it's so persistent, it presents a larger chunk of the population in need. Bipolar disorder, which is more frequent by comparison, lists a proportion of severe or poor outcome cases so it's not quite as highly represented, but getting up there as well. Other disorders, like severe depression, anxiety and alcohol-related disorders, also play a role.

How are we doing for time, by the way?

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The Chair (Mr. Kevin Daniel Flynn): You've still got just over two and a half minutes.

Dr. Peter Turner: I'm going to skip ahead to the Bethany bed status slide, and that slide indicates that Bethany, since about 1982, started with about 17 beds and then they were increased to 97 beds, and then to about 125 beds currently. In the meantime, the hospital beds were significantly reduced from, originally, 28 beds to about 16 beds currently, indicating, I think, that Bethany has probably picked up a lot of the more severely psychiatrically ill patients, because I go in there twice a week and see a lot of those clients on rounds.

Similarly, the PACT program for Halton, just looking at the hospitalization rates—Bethany does a very good job of looking after these clients. The PACT program has a hospitalization rate of somewhere around 10.7 days per year, down to 3.8 most recently, compared to Bethany hospitalization rates, in the next graph, showing that for Bethany—the blue or the smallest bar on the right-hand side of those graphs—psychiatric admissions are as low as one patient per year on average. That's very low compared to even the PACT program. It's about 20% of what the PACT program does, so we actually are five times more efficient than the best that the PACT program can do.

The next slide shows a little bit of the picture of what the program looks like—the building. It's privately owned. Sheri and Kevin Abraham, the owners, are here with me. It has regional funding. It's now at 126 beds. I added some graphs in to give you an idea of what kind of clients are in there. There's about 60% schizophrenia and a smaller proportion of bipolar and other disorders here. I think I'm going to stop on that. Am I almost out of time?

The Chair (Mr. Kevin Daniel Flynn): Actually, we've got about three seconds left. You must have some sort of psychic ability.

Dr. Peter Turner: In summary, I would just say that you can read the other things that are on the slides. Basically the Bethany program looks after 126 severely ill clients with very little funding. It has the potential to do more for the community and requires, also, increased

support and funding in order to continue to provide this quality of care that we've been doing for some time and trying to improve the programming for those unfortunate clients that we have.

The Chair (Mr. Kevin Daniel Flynn): Thank you. So, in summary, you're saying that by spending the same amount of money, we can get far more service and better outcomes for the people who are being served?

Dr. Peter Turner: Absolutely. In 15 minutes it's a bit hard to say everything, but it's a unique program. There's nothing else really like it in the province, or in Canada for that matter, that I've seen. We have fairly intense psychiatric care and supervision with such a large amount of clients with such a low re-admission rate. We're really saving hospital beds, in a sense, in that region, and looking after patients who otherwise would be frequent flyers in emergency rooms, in-patient services and out-patients in the hospital. It's a tremendously cost-efficient program. It's hard to say how much it actually saves but it could be in the millions.

The Chair (Mr. Kevin Daniel Flynn): And you'd be open to a tour by any members of the committee?

Dr. Peter Turner: Absolutely. I'd be very welcoming to any people coming by and happy to show you around and demonstrate exactly what we do. I can give you an actual copy of the PowerPoint presentation for people to look at on their computers, which is more readable than the printout.

The Chair (Mr. Kevin Daniel Flynn): I don't live too far from Bethany, so I'd be happy to arrange something through Kevin one day and take a tour myself.

Dr. Peter Turner: We look forward to that.

Ms. Sheri Levy-Abraham: Could I just add one thing? In terms of Bethany's uniqueness, our age group is all the way from 20 to 100. You can age in Bethany, age in place, because you can move throughout Bethany depending on your needs. Also, depending on where you are with your psychiatric illness, you can move around to be more independent or if you require more care.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today and for your presentation.

BOB LESTER

The Chair (Mr. Kevin Daniel Flynn): Our final presentation today is Dr. Lester, if you'd like to come forward. Some of us have heard you before. Thank you for agreeing to give us a more intimate presentation today. Like everybody else, you get 15 minutes. You can use that any way you see fit, and if there is any time at the end, maybe we can have an exchange.

Dr. Bob Lester: Thank you very much. I know you're all tired and probably want to get home. As Mr. Flynn said, my name is Bob Lester. I'm a professor emeritus in medicine at the University of Toronto, and in a past life I was the executive vice-president of medical academic and chief medical executive at Sunnybrook.

However, I'm here today to speak to you as a caregiver. My interest in presenting to you was sort of sparked by the fact that in my early discussions with

ministry officials who were charged with developing the 10-year strategy, there was an almost complete absence of mention of dementia and probably not much recognition that dementia is a mental health issue. My concern was that dementia once again was going to be falling through the cracks.

As those of you who have heard me before know, my real interest in this was triggered by the fact that my wife of almost 49 years—in three weeks—has developed advanced frontotemporal dementia.

I've documented this thing as a catharsis for my own mental stress in something that I've called a Journey into Dementia or the Absence of Presence. I think the juxtaposition of the words, "the absence of presence," really describes what goes on in a person who has dementia. Although it primarily recounts our family and my personal experience as a caregiver, I've had the opportunity to reflect on the inability of our health care system to handle the tsunami of dementia that experts are predicting. I feel that my experience of over 45 years in health care as a physician, a hospital executive and recently as a consultant with the Ontario Hospital Association, together with my experience as a caregiver, equips me to speak on this issue.

Just to clarify, the term Alzheimer's disease is often used as a surrogate or synonym for dementia; however, it is only one type of dementia. It is the most common type of dementia, but there are many other forms including vascular dementia, frontotemporal dementia, Creutzfeldt-Jakob disease and Lewy body dementia. Alzheimer's disease, the most common form of dementia, affects men and women of all races, religions and socio-economic backgrounds. All forms of dementia are diseases of the brain. They are diseases of the brain; they are not a normal part of aging. And no one is immune.

My wife was diagnosed at age 62 and, as I think back, the process likely started in her mid-50s; I just missed it. Dementia erases memory, alters personality, steals the ability to think and makes simple tasks such as eating or getting dressed impossible. It robs independence and eventually takes life.

My wife was an excellent athlete and a psychotherapist. She is presently confined to a wheelchair, is incontinent, is unable to speak, has to be fed and does not recognize me, her children or her grandchildren. I always thought that the worst thing in life would be losing a loved one to cancer or heart disease. I now realize that as painful as that must be, there is an end and to some degree, life can go on. For me, watching Judy deteriorate slowly over several years seems so much worse. Death seems to be occurring in an incremental fashion. The grieving process is frozen; there is no end to the grief.

1800

The scary part is that the prevalence of dementia is increasing at an alarming rate. Today, half a million Canadians, or 1.5% of the Canadian population, live with Alzheimer's disease or related dementia. The number will increase by half in just five years and will more than double in 25 years, representing 2.8% of the population. The majority of people with Alzheimer's disease is over

the age of 65. Huge numbers of baby boomers are now entering the years of highest risk. One in three will develop Alzheimer's disease or related dementia.

New statistics also confirm that younger people are increasingly stricken with dementia: One in six of those with dementia is under the age of 65. Clearly, dementia is not just a geriatric problem.

Presently, there are no cures for dementia, but there are drugs that can delay the onset of symptoms, especially if the diagnosis is made in the early stages. Researchers hope that within five to seven years, treatment attacking the disease process itself, not just the symptoms, will be available.

In addition, as the prevalence of dementia grows, so does the community of families and caregivers who look after loved ones. For every person with dementia, 10 to 12 others are directly affected. With the increasing incidence, it is likely that each of you in this room will be touched by this disease. You will develop dementia yourself or a close family member will—your parent or your spouse.

Caregiving is a critical issue for people living with loved ones suffering from dementia. According to the Canadian Caregiver Coalition, one in five Canadians 45 years and over provides some form of care to seniors who have long-term health problems such as dementia. Almost half are between the ages of 45 and 54, many caring for an increasingly needy parent while caring for their own family at the same time.

A quarter of caregivers are seniors themselves, and a third of them, over 200,000 people, are 75 years old and older. Family caregivers are the invisible and hidden backbone of the health and long-term-care system in Canada, contributing over \$5 billion of unpaid care. Caring for someone with dementia is difficult and distressing. It often leads to financial, mental and physical health problems, further taxing social and health care assistance.

Dementia is more than just an important health concern. It is has the potential to overwhelm our health care system if fundamental changes are not made in research, funding and care delivery. Dementia currently costs Ontario's health care system \$5 billion per year. That number will rise to an estimated \$15 billion if we don't find a cure. Experts predict that by 2025 it will carry the heaviest economic burden of any disease in Canada.

Dementia results in more years lived with disability than stroke, heart disease and all forms of cancer. Over 70% of those living in Ontario long-term-care homes have Alzheimer's disease or a related dementia. It has been estimated that 25% of all alternative-level-of-care beds and 33% of all alternative-level-of-care days are related to patients with dementia.

We are all familiar with the long wait times for long-term-care beds not only from hospitals but also in the community. My wife was on a waiting list for almost two years. If we can't manage the problem now, what are we going to do when it is projected that the demand for long-term care will be exponentially increasing over the next

30 years? In five years, as I said, the number of people with dementia will have increased by 50%.

Delaying the onset of symptoms of dementia by just five years could, over time, decrease by 50% the number of people with more advanced disease requiring complex community or institutional care. The saving of health care dollars would be huge.

While recognizing the importance of all the other mental health issues you are grappling with, is there another disease where the investment in research, health promotion, early detection and intervention could have a greater payback to society?

The Alzheimer Society is trying to convince the federal government to adopt a national Alzheimer or dementia strategy. They will be releasing an important report in January called the Rising Tide. The numbers will more than give you pause—they will chill you, they will scare you. They certainly did that to me.

Ontario has the opportunity to lead the way by showing that you have seen what the future will look like if we do nothing about dementia, and you refuse to go there. Addressing the issue of dementia must be an important part of Ontario's mental health strategy.

Thank you very much for listening to my presentation.

The Chair (Mr. Kevin Daniel Flynn): And thank you, Dr. Lester. I think we've got time for one question each, starting with France.

M^{me} France Gélinas: Thank you very much for coming. You are a very powerful speaker. It's the second time I've heard you speak, and both times you got your point across really clearly. It is a little bit scary. Basically, you would like research, health promotion and early detection. You talk about the Alzheimer Society. What is it out there that looks promising, that we should look into, that we should invest in that is off the ground and ready to run?

Dr. Bob Lester: I think there are a number of things. First of all, there are some very simple strategies that this Rising Tide paper will indicate, which are basically the same that are going to promote health in any other disease. There's the whole issue of navigation through the system, which is difficult. I've been in the system my whole life and I still had trouble navigating the system. There's looking after the caregivers; that's a huge problem. And then there's the whole issue, now, of better imaging, earlier ability to diagnose disease. The earlier you can diagnose this, the early you can intervene. Finally is this whole exciting area of new drugs that could actually attack the disease itself and perhaps prevent the onset of dementia. I think it's that whole package that we need to look at. Given the magnitude of the problem, it really becomes important to look at it.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Dr. Lester. This side, Maria?

Mrs. Maria Van Bommel: Dr. Lester, you talked about how you missed the early signs of the dementia onset in your wife. You're right, most of us have something in our families, too. I certainly noticed that in my mother-in-law we missed it in the early years. Actually, my father-in-law spent a lot of time hiding it and protect-

ing her from the family knowing that she had dementia. What are some of the early signs? Because that's part of the problem, I think, that the person who is actually suffering from dementia doesn't recognize it or is maybe in denial. What should we make the public aware of in terms of identifying it early enough to get them the help they need?

Dr. Bob Lester: I think that's a great question. The signs and symptoms will alter from person to person. In my wife's case—and again, I totally missed it—there were issues around her driving. We went down to visit our son who lives in Scottsdale and she went for a walk and got lost. I said, "Well, all the houses in Scottsdale look the same. No wonder she got lost." So I kept excusing her.

I think there's not a lot in primary care that helps people detect dementia early. There isn't a good single, simple test that can be applied to act as a screening test for dementia. I've been after people at Sunnybrook now to help develop an early screening test. The mini mental state examination—you've got to be pretty well gone before you fail that thing—is really not a great screening test. I mean, if you can't remember what province you live in or what year it is, it's pretty late.

I think the message that went out around stroke, when you saw those nice little TV blurbs, is the kind of message that we need to get out so that people recognize that there is a problem and can begin to recognize it as they now know what to look for in an early stroke.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Dr. Lester. Final question for the day: Christine.

Mrs. Christine Elliott: Thank you very much, Dr. Lester. It is a quick question, and you've really alluded to care for the caregivers. One of the things that I've certainly heard in my community is that there is a real lack of respite services for the caregivers. During the two-year period that you were waiting for your wife to get into a long-term-care home, did you experience that as a significant problem for yourself and your family members?

Dr. Bob Lester: I did. I'm going to say yes and no to that question. I did, and when I examined the options, I decided I didn't like any of the options. Fortunately, I was in a financial situation where I could actually hire someone to live with me and my wife to help me look after her. In a previous talk I had indicated that it's costing me close to \$70,000 a year to look after my wife. That's my choice, but I think that's the kind of care that everybody should get.

My wife's in Baycrest. It's a world-class organization. They do not have the staff to look after my wife. If I'm not there or someone's not there to feed her, she doesn't get fed regularly. She doesn't get changed; she doesn't get washed regularly, and this is a world-class organization. I shudder to think what must be happening in some of the other facilities. I think it's a huge problem for caregivers. I've been fortunate because I've been able to generate enough income to look after my wife, but I'm sure—in fact, I know—most people aren't as fortunate as I am.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Dr. Lester, for coming forward once again and telling your story. I think people are starting to listen.

Dr. Bob Lester: I hope so.

The Chair (Mr. Kevin Daniel Flynn): Thank you. It's a pleasure having you here today. We're adjourned.

The committee adjourned at 1808.

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Select Committee on Mental Health and Addictions

**Mental Health
and Addictions Strategy**

Comité spécial de la santé mentale et des dépendances

**Stratégie sur la santé mentale et
les dépendances**

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SELECT COMMITTEE ON
MENTAL HEALTH AND ADDICTIONSCOMITÉ SPÉCIAL DE LA SANTÉ
MENTALE ET DES DÉPENDANCES

Wednesday 9 December 2009

Mercredi 9 décembre 2009

*The committee met at 1603 in committee room 1.*MENTAL HEALTH
AND ADDICTIONS STRATEGY

The Chair (Mr. Kevin Daniel Flynn): Welcome to the final meeting of the year for the Select Committee on Mental Health and Addictions, or the final planned meeting.

MINISTRY OF HEALTH
AND LONG-TERM CARE

The Chair (Mr. Kevin Daniel Flynn): We're hearing today for the next hour, between 4 o'clock and 5 o'clock, from the Ministry of Health and Long-Term Care. We've got Fannie, Diana and Priti. If you'd like to come forward and make yourselves comfortable.

Thank you very much for coming today. Our understanding is that you wanted to make a presentation and that we would save some time at the end for a discussion, perhaps, of some of the questions that some of the committee members have as a result of previous delegations that we've heard from, and also as a result of your presentation today.

Ms. Diana Schell: Mr. Flynn, I think our understanding might be a little different. If I might just briefly say, I'm Diana Schell and this is Fannie Dimitriadis. Priti Sachdeva is not coming today. After we spoke to Ms. Hull about what was anticipated for today, we decided we didn't need Priti.

Our understanding is that the committee would like some high-level information related to two issues that you've been hearing about, the first being the difficulty getting treatment for mentally ill family members and the second being the difficulty getting information about family members—so information and treatment issues. We were asked to provide a high-level statement about what the law is in this area and then make ourselves available for any questions the committee may have, and it was our understanding that most of the committee time would be taken up with your questions.

If you are okay with this, what we're proposing to do is just say what we have to say at the beginning and then leave as much time as possible for questions.

The Chair (Mr. Kevin Daniel Flynn): I think we're saying the same thing in different ways. Our expectation

is that most of the hour be taken up by a discussion, based on some of the things that perhaps you'll make us aware of in your statements.

Ms. Diana Schell: Certainly. Thank you, sir.

I'm going to talk about the treatment issues. The first thing I'd like to say is that the relevant legislation in this area in Ontario is the Health Care Consent Act, 1996. That act has been around since March 1996 and it applies to treatment provided by health practitioners. If one looks at the definition of "health practitioner" in the act, what you see is that that definition encompasses professional groups that are regulated health professions, so physicians, nurses, physiotherapists—people who are regulated under provincial regulation.

The act has a definition of "treatment." It indicates that treatment "means anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose." The treatment in question is treatment provided in any setting. This is not legislation that applies exclusively to institutional settings; it's really treatment that's provided by a health practitioner. The place of treatment is not relevant for the purposes of this legislation, at least in the treatment part of the legislation.

Under the act, the issue of capacity determines who may make a treatment decision. So if an individual is capable with respect to the particular treatment decision, then that person makes a decision about whether to consent to the proposed treatment or to decline the proposed treatment. If the person is not capable, and it's the health practitioner who is supposed to make that finding, then a substitute decision-maker is supposed to make the treatment decision.

1610

There's a list of substitute decision-makers in the act and, for the most part, I think it's family members who would be substitutes, although there is a possibility of a guardian appointed by the court or somebody with power of attorney where the donor of the power of attorney is the person who's going to be treated.

There is a test that the substitute is supposed to apply when making a treatment decision on behalf of an incapable person. Basically what that's about is the substitute is supposed to comply with any prior capable wishes that the person expressed that apply to the circumstances and that were expressed after the individual was at least 16 years of age. If there are no prior capable wishes that the substitute knows about, the substitute is

supposed to make a decision that's in the best interests of the incapable person.

I know that you're interested in information issues, so I'll just tell you very quickly that the act says, in section 22, that a substitute decision-maker is entitled to all the same information that the person would be entitled to for the purpose of making an informed decision about the proposed treatment.

That's all I have to say for the moment, but after Fannie presents, I'll be pleased to answer any questions you may have.

Ms. Fannie Dimitriadis: I'll just take a few minutes to give you a brief overview of some aspects of the Personal Health Information Protection Act. I'm sort of anticipating some of the areas that might be of interest to you, so I'll focus on those.

The act received royal assent in 2004, so it's relatively new, although it has been around for a few years. The purposes of the act are set out in section 1, and they include establishing "rules for the collection, use and disclosure of personal health information about individuals that protect the confidentiality of that information and the privacy of individuals with respect to that information, while facilitating the effective provision of health care."

The act applies to health information custodians. That's a defined term that includes health care providers, such as hospitals, long-term-care homes, physicians etc. when they collect, use, and disclose personal health information. "Personal health information" is also a defined term. It means generally what you would think of as being health information when you can identify the individual to whom the information relates.

It's important to note that PHIPA is consent-based legislation, so that means that the individual's consent is required for the collection, use and disclosure of information about that individual, except where that collection, use or disclosure, as the case may be, is permitted to occur without consent. Consent can be implied in certain cases, when the personal health information is collected, used and disclosed among health information custodians who are involved in providing health care to the individual. But consent in other cases must be express, when the information is disclosed to individuals who are not custodians or where the purpose is not the provision of health care. PHIPA includes the elements of consent. It requires that consent be from the individual or an authorized substitute decision-maker, be knowledgeable, relate to the information and not be obtained through deception or coercion.

PHIPA includes a scheme governing the determination of capacity and a scheme for substitute decision-making in relation to decisions about personal health information transactions covered by the act. Largely, they parallel those that Diana just talked about in the Health Care Consent Act. They were modelled on those provisions.

Health information custodians are entitled to presume that an individual is capable of consenting to the collection, use and disclosure of their personal health information unless it is not reasonable to do so. An individual

is capable of so consenting if the individual is able to understand the information that is relevant to the decision of whether to consent, and able to appreciate the foreseeable reasonable consequences of giving, not giving, withholding or withdrawing consent. Under PHIPA, it's the custodian involved in the collection, use or disclosure, as the case may be, who determines capacity.

Where a custodian makes a determination of incapacity, unless it's not reasonable to do so, he or she is required to provide information to the individual about the consequences of the determination, such as the fact that the individual has a right to have a review of that finding and that someone else will be making information decisions on his or her behalf.

The act allows persons who are determined to be mentally incapable of making decisions to apply to the Consent and Capacity Board, which was established under the Health Care Consent Act, for a review of that determination.

PHIPA provides a framework for making decisions about the collection, use and disclosure on behalf of people who are not capable. Where an individual is not capable with respect to such a decision, the act provides a list of substitute decision-makers—again, this parallels the scheme in the Health Care Consent Act—and there's a ranking in the legislation of individuals who can take on this role.

Diana referred to one provision in the Health Care Consent Act regarding the fact that individuals who are substitute decision-makers under the Health Care Consent Act have the right to information to allow them to make those decisions, and there's sort of a parallel provision in PHIPA to allow the two acts to meet together.

In making decisions on behalf of an incapable individual, a substitute decision-maker must take into consideration a number of factors set out in the act, including the wishes, values and beliefs that the substitute knows the incapable individual held when capable.

As I mentioned, the general rule in PHIPA is that consent is required for the collection, use and disclosure of information. There are some instances when consent is not required, and I'll just highlight two for you, as they might be relevant to your work here.

Facilities that provide health care can disclose limited information about their patients' and residents' location and health status. They can let people know the fact that the individual is a patient or a resident in the facility; the individual's general health status, described as critical, poor, fair, stable or satisfactory or something along those lines; and the location of the individual in the facility. That's permitted to occur if, at the first reasonable opportunity after admission, the individual is provided with an opportunity to opt out of this kind of disclosure of their information.

There is a provision as well that provides custodians with the discretion to disclose personal health information without the consent of the individual to whom the information relates where the custodian believes, on reasonable grounds, that the disclosure is necessary for

the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons. The Information and Privacy Commissioner, the body responsible for oversight of compliance with the legislation, has provided some guidance on that particular provision.

At that point, I'll turn to you, if you have any questions for Diana or myself.

The Chair (Mr. Kevin Daniel Flynn): I'm sure there are some questions. Thank you very much, both of you, for your presentations. Let's start on this side. Christine?

Mrs. Christine Elliott: Thank you very much for coming to the committee and sharing your expertise with us. We have a number of questions we'd like to ask your opinion on, as we're sort of grappling with some of these issues.

One of the things we've heard about repeatedly from family members is that their loved one—usually a son or daughter—clearly—in their view, anyway—needs to get some help. They may be taken to hospital. They may or may not be admitted on a form 1. But the key seems to be that they may get released after 72 hours with, “Okay, you're on your own,” and not much follow-up. The family members don't get notified so they often don't even know that their son or daughter has been released. So they're asking us to do something about that, both with respect to the Mental Health Act being able to keep someone on a form, either a form 1 or subsequently on a form 3, and with respect to the release of information to family members. The consent issue, of course, has to be there. But capacity seems to lie at the heart of it—whether a person has capacity or not.

1620

One of the issues that we've been talking about is: Is there an opportunity for capacity to be determined at an earlier time? Perhaps when someone initially comes in on a form 1, is there an opportunity? Have you given any thought about having an earlier capacity assessment so that a substitute decision-maker can then make decisions, if necessary, or the person can then proceed to make their own? Because what we seem to be hearing from family members is, “They don't know what they're doing and they're back out on the street, and we have no way of getting help for them.” I'd really appreciate your comments on that.

Ms. Diana Schell: This is, I think, really more of a question about the application of the Mental Health Act. When that act was amended in 2000, there were some criteria added that allow for a form 1, form 3 or form 4 on new grounds that it include a consideration of the person's capacity. So it's always possible that when somebody comes into hospital, a clinician—usually a physician—has already looked at the issue of capacity. I think more typically the situation is that capacity may not be assessed at an early stage because the staff at the psychiatric facility are in the process of doing an assessment and they may not have treatment that they're prepared to recommend at that point in time.

Capacity assessments are done with respect to particular proposed treatment. They don't apply to a

finding of capacity at large, if I can put it that way. The assessment of capacity is done when the clinician is prepared to make a proposal about particular treatment, so it's an assessment with respect to that treatment. I think that that may be one reason why capacity assessments are not made immediately when the person first comes into hospital.

Mrs. Christine Elliott: I'm just wondering how we deal with the revolving-door issues that we seem to hear about with so many people: They go into the hospital, they may or may not be kept on a form 1; if they are, then they're released after 72 hours. They get sicker, a family member brings them back in, and multiple admissions to hospital—or visits to hospital; maybe not admissions. What would be your recommendation? Is there anything that we can do in law to change the system to make it more effective so that we can actually help people more?

Ms. Diana Schell: The short answer is, I'm not sure that that is specifically a legal question. It might be more a question about program design, but I think that there was an attempt to deal with some of these revolving-door issues in 2000 with the enactment of the community treatment order provisions and the changes to the form 1 and the involuntary admission provisions that I mentioned just a moment ago. I'll just find those criteria for you, because that might be a helpful way to proceed.

It would be more helpful if I looked in the Mental Health Act instead of the Health Care Consent Act.

Okay. The new involuntary-admission provisions are in subsection (1.1) of section 20 of the Mental Health Act. The criteria there are lengthy. I'm not going to read them all verbatim, but they talk about the ability to continue a person as an involuntary patient where the person “has previously received treatment for mental disorder of an ongoing or recurring nature that, when not treated, is of a nature or quality that likely will result in serious bodily harm to the person or to another person or substantial mental or physical deterioration of the person or serious physical impairment of the person.”

So it's there that the attempt was made to address the problem you've identified, Ms. Elliott, with respect to people who have a history of repeated admission to hospitals. This addition was intended to allow a clinician to intervene at an earlier stage before there was substantial mental or physical deterioration.

That's what was done as of December 1, 2000. Whether there's more that might be done of a practical nature, I'm not sure.

Mrs. Christine Elliott: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Helena?

Ms. Helena Jaczek: Thank you, because I want to pick up exactly on that point. Involuntary admission: On that first admission, it's required to show that there's some sort of serious bodily harm occurring, either to the individual or to someone else. What we've heard from parents of schizophrenic children is that might not necessarily be the case, this issue of serious bodily harm. It's clear that things are very wrong, but that might not necessarily be the situation, so they may not be able to have a form 1 used for that first admission.

The deterioration criteria that you're talking about requires a history, so one can see that having had previous hospitalization, subsequently the test seems to be less onerous in terms of this serious-bodily-harm piece. How would you respond, or would you think there's any way of, for that first admission, somehow, perhaps, softening this requirement for serious bodily harm?

Ms. Diana Schell: I appreciate that people are reporting to the committee what their understanding is of the law and they're saying what they've been told. I think that your description of the serious bodily harm requirement is actually not entirely accurate. What the act provides for is, if we're talking about a form 1, which any physician can do after examining a person in the community, the physician has to be of the opinion that the person is apparently suffering from a mental disorder of a nature or quality that likely will result in—and then there are various possible harms: There's the serious bodily harm to the person or someone else; there's also serious physical impairment of the person, which would be in the nature of unanticipated risks that the person exposes himself or herself to because they're ill and they don't appreciate the nature of the risk.

In looking at the serious-bodily-harm requirement, the courts said many years ago that what's required there to support that kind of finding by a physician is either the physician's opinion that the person is suffering from mental disorder of the sort that is likely to result in that kind of harm or a history of past harm. So there is, in fact, no requirement that the person is actually suffering serious bodily harm right now in order to detain the person as an involuntary patient or to complete a form 1. Certainly, if they were, that would satisfy the ground, but it's not a specific requirement.

Ms. Helena Jaczek: I think we're going to be hearing, a little bit later, from Dr. Gray from BC, and apparently they have changed some wording that softens that requirement related to this physical harm or threat of physical harm. We certainly heard from parents that they couldn't get the kind of treatment that they felt that their loved one needed.

Ms. Diana Schell: That's very possible. If British Columbia's considering other wording or has put in some other wording, that's something that I'd be pleased to know more about.

I think it's possible, as well, that the description that's provided to family members about how onerous these criteria are might be a little overstated. I am not saying that's deliberate, but I think that in my experience—and I've done many Consent and Capacity Board hearings, and for years I was doing almost all of the appeals involving the provincial psychiatric hospitals—certainly, it was not my experience that the courts were overly zealous in placing a very high interpretation on these provisions that made it difficult for them to apply.

Ms. Helena Jaczek: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Anything, Howard?

Mr. Howard Hampton: No, nothing.

The Chair (Mr. Kevin Daniel Flynn): Any other questions? If not, thank you very much for coming today, unless you've got something, Liz?

1630

Mrs. Liz Sandals: What we frequently deal with is a family who very much wants to get care for a family member, and they may either not have been allowed a relationship with the patient's doctor—and I've run into that where there just simply is no relationship with the patient's doctor, so I don't think the doctor would have any way, particularly, of accurately judging their good or bad intents—or they may have had a little bit of consultation or have met, but not much interaction with the health care system that has actively been treating. Then it falls off the rails. Then they're desperately trying to figure out how to get treatment back on the rails and don't seem to be able to find any route back in.

What legal opportunities—if you look at the family, what is a family in that situation currently going to have to step through in terms of process to actually try to get some help for their family member? If that's the situation you're starting from, what would you do?

Ms. Diana Schell: I think part of your question is about access to services and how do family members get information about the services that may be available for their family member—

Mrs. Liz Sandals: No. In most cases, they have a pretty clear view of what services are available in the community. In many cases, they've already done quite extensive research. I come from a community where there's 120,000 people. You don't have to do too much research to find out the two or three things that are available in the community. So they know pretty much what it is they need. Their problem is that they've got a family member who's typically off medications, the family member is refusing treatment, they know that they need to get the family member back on medications but there doesn't seem to be a way for them to intersect with the medical community because they're not the patient.

I've had constituents who—ultimately the family member has committed suicide because the family member can't seem to get through this legal wall to say to somebody, "My family member isn't making good decisions; my family member desperately needs treatment." In that situation, they know where they need to get, but how can they get to where they need to get to try to help the family member?

Ms. Diana Schell: Okay. I can tell you about what's in the Mental Health Act now that can result in somebody's admission to a psychiatric facility. I don't know that it's a complete answer to your question, but I'll tell you what's here now.

Leaving aside the problem with connecting with the family member's physician, there is always a possibility of the physician arranging a voluntary admission to a psychiatric facility. If the person is incapable with respect to treatment, a substitute decision-maker can consent to that admission. The roots—

Mrs. Liz Sandals: But doesn't that assume that while the patient was in good shape or at least had some

capacity, they had the foresight to do that? Typically we're talking about a situation where there wasn't the foresight on the part of the patient to name a substitute decision-maker, so there is no substitute decision-maker.

Ms. Diana Schell: Well, if the person's incapable, there's always a substitute decision-maker identified under the act. I'm going to tell you about the ways that don't involve a co-operative response from the person who's going to be admitted.

Under section 17 of the Mental Health Act, there are criteria that may allow a police officer to take a person to a physician for an examination. There's the form 1 process that Mrs. Elliott has alluded to, and that's an examination by a physician. You have this process that starts with the physician's examination.

The route that seems to be open to family members in addition to that is something called a form 2, under section 16 of the Mental Health Act. That's an order for examination by a justice of the peace. A family member can, in fact, apply for a form 2 order. That would require that the person be examined by a physician. The physician can then do a form 1, which would lead to the person's admission to a psychiatric facility for the purpose of an assessment.

Those are the routes into hospital under this act. They all start with this idea that there has to be a process for obtaining an examination by a physician who can then do a form 1, which may or may not lead to either a voluntary or an involuntary admission to a psychiatric facility. Those are the things that the legislation provides for now.

Mrs. Liz Sandals: Is there any tracking of how often form 2 is successful in the case where the family and the doctor aren't already working together? I'm assuming that the family and the doctor are not co-conspiring—if I can put it that way—that you've got the family who's sitting here. The patient may not even have a current doctor because they've broken those medical connections. Do we have any tracking that shows how often these instruments are successfully used by a family member in order to access treatment?

Ms. Diana Schell: I have no idea. That wouldn't be something that falls within the scope of what I do, so I don't know if there's any tracking. I can tell you that a form 2 application can be made without having to have clinical evidence to support the application, but whether anybody is tracking form 2s, I have no information about that.

Mrs. Liz Sandals: Not the Ministry of Health, then, I think, from what you're saying.

Ms. Diana Schell: Well, again, I don't know. I think it's possible that data may be collected with respect to the number of individuals who come into hospital on a form 2. I don't know whether that's the case or not, but I think it's possible that the ministry collects that kind of data from the health care system. I'm just speculating in that regard; I wouldn't know for sure.

Mrs. Liz Sandals: Just by way of comment, my sense would be that in my community, the folks who would come into hospital, it would tend to be that they've been

picked up by the police, that the situation has deteriorated to the point that somebody is picked up by the police. Unless the family has called the police, there doesn't seem to be a way to get there without first of all involving the police, which sometimes can backfire, with people ending up in jail, which wasn't actually the intent of the family. Anyway, that helps.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Liz. Helena?

Ms. Helena Jaczek: Yes. On the PHIPA side of things, the privacy commissioner did make some recommendations to the Standing Committee on Social Policy. I forget—I was actually on the committee—whether it was last year or earlier this year. It related to this issue of bodily harm. She made the recommendation that PHIPA should be amended to replace "bodily harm" with "physical or psychological harm." I'm wondering if you'd have any comment on that.

Ms. Fannie Dimitriadis: I can tell you that from the perspective of the lawyers who work in our branch, the legal services branch, that we interpret bodily harm as including that psychological harm. The language that was selected for the purposes of PHIPA aligns with the language in other Ontario legislation.

Ms. Helena Jaczek: I see. I would have thought from a lay point of view that "bodily" would somehow imply more physical?

Ms. Fannie Dimitriadis: That's the way we interpret it, based on case law, to that effect.

Ms. Helena Jaczek: You would assume psychiatrists, family doctors or anyone who might be involved in a case of mental illness would also interpret it that way?

Ms. Fannie Dimitriadis: I'm sorry. I can't comment on whether they would or they wouldn't. It may be that the kinds of physicians typically involved in dealing with these kinds of matters would have more knowledge than the average family doctor. I'm not sure, though. I'm just speculating.

Ms. Helena Jaczek: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Are there any further speakers? Christine.

Mrs. Christine Elliott: I just have one further question with respect to consent and the capacity issue. Consent is presumed unless it would be unreasonable to presume under PHIPA. What kind of criteria that you know of would be applicable in that situation?

Ms. Fannie Dimitriadis: Well, an obvious one, not especially relevant to what we're talking about here, is if somebody's unconscious, for example. Obviously, they're not capable of making a decision themselves. Just through their discussions with the patient: How are they responding to questions? What kind of information are they providing? Does it appear as though they're understanding what's being discussed, the impact of their decisions etc.?

Mrs. Christine Elliott: But that seems to be the really grey area that we're dealing with.

Ms. Fannie Dimitriadis: Yes.

Mrs. Christine Elliott: It's sort of like an informal capacity assessment, really, to determine if the person is mentally capable of giving the consent. That's where I think we run into a lot of frustration with family members. They're saying, "They can't consent because they don't know what they're doing." Do you think that that's something that we could look at as an area that needs maybe some change or amendment?

Ms. Fannie Dimitriadis: I'm not sure because I haven't necessarily heard all the information that you've heard along the way. The scheme in PHIPA, as I mentioned before, does parallel the Health Care Consent Act scheme. It does simplify it a little bit—if that's the right word—acknowledging the fact that making decisions about treatment is different than making decisions about collection, use and disclosure of health information. That distinction was deliberate there. I'm not sure if that's helpful in response to your question.

Mrs. Christine Elliott: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Okay. Any other questions? If not, I'd like to thank both of you for appearing today. Thank you very much.

Ms. Diana Schell: A pleasure.

Ms. Fannie Dimitriadis: Thank you.

The Chair (Mr. Kevin Daniel Flynn): For the committee members, Dr. Gray has arrived, but I understand he needs a little bit of time to set up. Maybe we'll call a brief recess. How much time do you think you'll need? Five minutes? Five minutes. Okay.

The committee recessed from 1640 to 1657.

JOHN GRAY

The Chair (Mr. Kevin Daniel Flynn): We can call to order again, committee. We've been joined now, as you will all have noticed, by Dr. Gray from British Columbia. Dr. Gray is going to make a presentation somewhere in the neighbourhood of 30 to 40 minutes, and then after that, he's open to questions from the committee.

Having said that, welcome to Ontario. Thank you for joining us. The floor's all yours.

Dr. John Gray: Thank you, Mr. Chairman, and committee members. It's a privilege to have been asked by this important select committee to share information on how other provinces and territories in Canada have dealt with the issues which witnesses before this committee have identified in the Mental Health Act, the Health Care Consent Act the Personal Health Information Protection Act.

I come to this interesting task being the lead author on a recent book called Canadian Mental Health Law and Policy—here's my prop—working in Saskatchewan and British Columbia and having ties to Ontario. These include being an adjunct professor at the University of Western Ontario and authoring or co-authoring about 14 papers relevant to the sort of issues you're talking about.

The latest paper is called Treatment Delayed—Liberty Denied. The lead author is a law professor at UWO, Robert Solomon, and co-author, Dr. Richard O'Reilly. It's been recently published in the Canadian Bar Review.

As an aside, I might just mention that this latest study examined the plight of patients who because of Ontario law could not be treated. They could not, therefore, get well enough to be released. Examples in this paper are of people being detained without treatment for five, and two at 20 and one at 25—not months, but years; detained 25 years because they couldn't be treated. At \$600 a day in hospital, or \$219,000 a year of wasted money or \$4.38 million for 20 years, that's a lot of taxpayers' money not to treat people and to deny them their liberty.

This paper that we wrote in Ontario could not have been written in British Columbia or most other provinces in this country or most other countries because they would treat people in these circumstances and they would be discharged.

Through my involvement with the Canadian Mental Health Association and also the Schizophrenia Society in BC and in Canada—I'm a past president of the Schizophrenia Society of Canada—I've heard a lot from families and consumers about problems with mental health legislation. Before I get into the detail, though, let me cover off a number of, I think, quite important points.

The first one is about the voluntary nature of treatment whenever we can manage to have it voluntary; in other words, voluntary treatment is to be preferred. Voluntary consent from the individuals themselves is always the preference, and efforts must be made to work with individuals with mental illness to encourage their acceptance of treatment.

The system also should develop services and ways of approaching people to encourage voluntary acceptance of treatment, but unfortunately some people with brain illnesses, such as schizophrenia and bipolar disorder, are unable to understand that they are ill, and this leads them to refuse treatment. So no matter how sensitive and how comprehensive your services become, you will still need a Mental Health Act.

The second point: Mental illnesses that affect insight are most likely to result in involuntary services. Unfortunately, many people with psychotic illnesses do not possess the insight that they have a treatable illness. This is caused by brain dysfunction. For example, although anxiety disorders can be very painful and very debilitating and are about 10 times as common as schizophrenia, you almost never see anyone in a psychiatric hospital as an involuntary patient with anxiety disorders—almost never. That is because anxiety disorders do not affect insight. In contrast, people with schizophrenia and bipolar disorder, where about half do not believe they are ill, make up most of the people admitted involuntarily. This lack of insight should be very important in designing mental health and information-sharing systems.

The third point: Mental health legislation provides access to treatment. Your committee has heard a lot about how more services need to be in place so people can access treatment. I absolutely support these efforts. But the people I am talking about can't access treatment because their brain illness prevents them from knowing they need it, leading them to refuse voluntary treatment.

You could have a perfect service system and people without insight would not take you up on it. In an equitable system, citizens should not be denied access to treatment because they have an illness that deprives them of understanding that they do need treatment. The illness denies the access.

The fourth issue: Consequences of not receiving needed treatment can be really quite severe. You have heard many personal stories in these hearings of what happens to people with a serious mental illness who cannot be treated because of the law. These include continued suffering, family disruption, harm to self or others, homelessness, suicide, lengthy untreated hospitalization, criminalization and stigmatization. Stigmatization of individuals can occur because of their odd untreated behaviour, but sometimes one untreated individual, such as Mr. Vince Li of Greyhound bus beheading infamy, can wipe out the positive gains made by numerous public anti-stigma campaigns very quickly. Interestingly, Mr. Li, who's a computer engineer, was released from an Ontario hospital, but he refused follow-up care. He is now doing well in treatment in Manitoba, but at what a cost to many people and what a cost to those who are trying to reduce stigma on mental illness.

The fifth point: Involuntary admission with treatment works. You've heard many accounts of people getting well once they got on the right treatment. Research bears this out and shows that the medications work and work well whether you're a voluntary or an involuntary patient, despite what some critics have told you in this committee. These involuntary treatments get people out of hospital in an average time of three weeks, and sometimes it's considerably less. Community treatment orders, which you've also heard about, have been shown to reduce readmission, reduce criminalization and reduce homelessness. Involuntary treatment is, unfortunately, essential for some people, to start them on their road to recovery.

The sixth point: Thirteen Canadian mental health acts provide many options. In my book, we compare provisions from the 13 different mental health acts in Canada. We also look at other countries. There are options in these acts for addressing the problems with Ontario legislation that you have heard, and that's what we'll get to now.

In discussing the present Ontario acts, I should mention that in the year 2000, partially in response to the tragic killing of broadcaster Brian Smith by a person with untreated delusions, the Ontario government did make significant changes to the Mental Health Act. They introduced the deterioration admission criteria and community treatment orders. These were good changes, but more needs to be done to address the problems you have been alerted to.

Now, let's look at the problems. The first one is to do with the serious bodily harm committal criteria. The problem in Ontario is this: In order to be admitted involuntarily on a first episode, a seriously mentally ill person must be likely to be physically dangerous; that is, in the

words of the act, likely to cause "serious bodily harm." And it doesn't include psychological harm, as was mentioned by the previous speaker. This leads to many people with a psychosis who are not likely to cause serious bodily harm to themselves or others, but who suffer or cause other serious harms, not being admitted.

The consequent serious harms of not being readmitted or being admitted can include, of course, homelessness, jailing, family disruption etc.

Dangerousness criteria also enhance or increase stigma, because you're linking those two things together.

Other provinces have either abandoned bodily harm criteria or they didn't take it up in the first place. It was actually an American import which not everybody bought on to—fortunately, from my perspective.

1710

Ontario introduced a new deterioration criteria in 2000, which does not require the person to be likely to cause bodily harm. However, the new deterioration criteria is not helpful for a person with their first admission because of several restrictive requirements. These include to have previously been successfully treated. Well, if you're on your first break, you can't have previously been successfully treated.

So families in this situation must wait and watch the person deteriorate until the person is likely to cause serious bodily harm to the person or another person or serious physical impairment. That is not easy to predict, and tragedies, including suicide and homicide and many lesser harms, have occurred waiting for the person to become dangerous enough to be hospitalized.

Some people in easily treatable manic states—and we're pretty good at treating mania—have lost their jobs, have lost their families and have run up huge bills because of their outrageous behaviour. Because they're not physically dangerous, they cannot be helped in Ontario, but they can be helped in other provinces, including British Columbia.

For young people, in particular, unnecessary suffering, prolongation of psychosis and worsening prognosis occurs because of this physical dangerousness criteria that you have. In appendix 2, you will see a study that provides evidence that "mental health laws that require dangerousness for involuntary admission may delay the initial treatment of schizophrenia." That is a very bad thing because delay worsens prognosis, plus it exposes the young person and others to risk while the person is psychotic.

There are at least 10 additional reasons why physical dangerousness, or bodily harm, criteria should be abandoned or have not been adopted, as is the case now in seven provinces. I'm just going to zip through these—there's quite a bit of detail in the handout you've got, but we do have a time constraint.

The first one is that it is not required by the charter, and I was involved in a case in BC where the court definitively said it is not. You don't have to be physically dangerous in order to qualify, according to the charter. There are Manitoba cases as well.

People are inappropriately excluded by the bodily harm criteria. I mentioned the non-dangerous people, early psychosis, people with mania. Some people, therefore, are inappropriately forced into jails and homelessness because of the harm criteria. People are inappropriately included by the physical harm criteria, because you're taking in dangerous people who are not necessarily treatable, like psychopaths. You've got them in hospital, and what can you do with them? Nothing, because you can't treat them, but because the law says you must take them, you have to take them.

Number five: the degrading overcrowding—that was true in the States and it's true here—in hospitals, when people started to think about this dangerousness criteria as a way of reducing the number in hospitals. That has changed, because our hospitals are now not the bins that they used to be.

Dangerousness is very difficult to predict, so it becomes an arbitrary criteria, because you might think that the person is dangerous and you might think that he isn't, because there's no real way of knowing.

People are stigmatized by the law that links dangerousness and mental illness. For these reasons, the bodily harm criterion is widely ignored.

In the US, a number of the states have changed their laws, and in many other democratic countries, like New Zealand, England, Wales, Scotland, Australia and the States etc., they either never adopted it or they have changed and broadened it.

So what's the solution to the problem that you've got? My suggestion is that you examine committal criteria concerning harm and deterioration now used in British Columbia, Alberta, Saskatchewan, Manitoba, Nova Scotia and Newfoundland and Labrador. This is what it is: that the person "is likely to cause serious harm to himself or herself or to another person, or to suffer substantial mental or physical deterioration if not detained in a facility."

The above provisions have allowed a majority of Canadian provinces to solve this problem that you have in Ontario, where a person for a first admission is not eligible unless they're physically dangerous. In other provinces "harm" is not confined to "bodily harm." In the BC court case that I was involved in, the judge said, "It can include harms that relate to the social, family, vocational or financial life of the patient."

The provisions adopted by other provinces would allow for the incorporation of the current Ontario physical dangerousness/harm criteria into a broader harm criterion and would simplify your deterioration criteria.

Another way to do it legislatively would be just to replace the word "bodily" with the word "harm." So instead of serious/not serious bodily harm, we would just have "serious harm."

There will be critics in Ontario of these proposals and the law in six other provinces who will say that these are not charter-proof and are overly broad. But the Attorneys General and the Legislatures of six provinces obviously don't agree with that, and a number of courts have also

found for broad committal criteria. Moreover, the deterioration criterion that Ontario has established does not require dangerousness, so it suggests that your AG doesn't believe that dangerousness is utterly critical either.

Critics of these sorts of laws will also rail about "street cleaning," that you're going to have masses more people committed. Well, the evidence in British Columbia and the other provinces that I cited is that that is not the case. There was a formal study done in the US where they did the same thing in eight states and found that it was not the case. What in fact happens is that it makes the law more responsive to the treatment access needs of people whose harmful illness precludes them from accepting treatment voluntarily.

The next problem is the refusal of treatment necessary for the involuntary patient's release. The problem is this: Treatment is necessary to help the involuntary patient get well enough to be released. I mean, it's sort of axiomatic, isn't it? However, in Ontario a capable involuntary patient may refuse treatment, and some incapable patients may have treatment refused for them.

Where an involuntary and incapable patient has a valid wish to refuse treatment, it must be respected by the substitute decision-maker. Treatment refusal leads to unnecessary loss of liberty, continued suffering, unnecessary health care costs and harm to others, such as assaults on nurses.

In a number of provinces in Canada, including BC, where the purpose of the act is to treat, authority to admit involuntarily carries with it authority to treat involuntarily. In other words, we say there's no point in involuntarily admitting people to a hospital if you can't treat them. Treatment cannot be refused for an involuntary patient and hence they get better; they get well. However, in Ontario, where the purpose is actually to detain, the treatment needed to release the person from detention can be refused. So a capable patient has an absolute right to refuse treatment forever and consequently to be detained for the same length of time.

Even the treatment of a patient who is incapable—and by that we mean incapable of making a treatment decision—can be refused. Liberating treatment can be refused either because the substitute decision-maker does not agree with the treating doctor and says, "No, you can't treat my son," or because the patient has a previously expressed capable wish, applicable to the circumstances, not to be treated: "Before I went into hospital, I said that I never want any of that psychiatric medication stuff, so don't give it to me"—and the mother, even though she knows you need it, can't.

This wish does not have to be documented, but the substitute decision-maker, usually a family member, must refuse the treatment, even though they are convinced that great harm will befall the patient if the treatment is not administered. And it does: Treatment refusal for an involuntary patient can cause great harms and is completely different from treatment refusal for a voluntary patient. If the voluntary patient refuses treatment, they leave the hospital. If the involuntary patient

refuses, they stay detained until there is a spontaneous recovery—in other words, they get well without treatment; some people do, but not many—they accept treatment and get well enough, or they die, whichever comes first.

The harms to involuntary patients and others where the means of liberation is refused are many and serious. They're well researched, and I've got them in my book there. They include things like denial of liberty—and that article by Dr. Solomon in your package is particularly helpful on this; continued suffering; increased use of restraints and seclusion; longer stays in hospital; poorer prognosis; negative effect on other patients; increased assaults on nurses; and compromising staff ethical standards. So health staff, in essence, become jailers because they can't treat anybody. They've just got to keep them locked up. And of course, there's family disruption and increased costs.

1720

Let me give you a bit more detail on one of the cases that Professor Solomon's and my paper addresses. This is about a Mr. Sevels. He was suffering from schizophrenia. He had previously responded well to treatment but he had to spend over 404 days—work that out in years and months—in seclusion, in solitary confinement, to protect him and others because the substitute decision-maker, in accordance with the Health Care Consent Act and Mr. Sevels's wish not to be treated, couldn't treat him. They took this to the court. A judge was asked to order treatment, but because of the Court of Appeal decision, he couldn't do that. The judge expressed his constitutional concern applicable to the Health Care Consent Act when he wrote this:

"It surely cannot be the intended result of the application of the Charter of Rights and Freedoms that persons who are entrapped in the cage of their mental illness ... be for prolonged periods caged and warehoused in mental health facilities where the key to their necessary and involuntary seclusion is available with relatively little likelihood of ... risk."

Mr. Sevels finally got out of seclusion—I'm not sure how. He stayed in hospital untreated for another five years. He then attacked a male nurse, seriously injured him and was then treated; exactly how that worked, I'm not sure either. But when he was treated, he improved to the point that in 2003, he was discharged on a community treatment order. As far as we know, he's doing well now. So for all those years, he was untreated and created all those problems for himself and other people. That wouldn't happen in BC.

What are the solutions? Nova Scotia and Manitoba have solved this problem. Both provinces—and it's quite different from BC, but I'll use theirs because theirs is the most similar to your legislation—still require the substitute decision-maker to follow the incapable involuntary patient's competent wish. However, if following the wish is likely to result in significant harm, the substitute decision-maker must make the decision in the patient's best interests. Best interests is a legal standard used in

many acts. It just basically means that the benefits of the treatment outweigh any harm, taking into account the person's values and ensuring that the treatment is the least restrictive and intrusive. It surely can hardly be in any person's best interests to be detained unnecessarily, sometimes for years, nor to be secluded or restrained nor possibly assault nurses or others as a result of untreated mental illness. I'm sorry, I should have given you that slide on that one.

This is for a person who's capable now. They came into the hospital as an involuntary patient, but they're capable of making a treatment decision, like Mr. Starson, whom some of you may know, and saying, "No, I don't want to be treated." So they just stay there and go on and on. But a number of provinces have raised the level of capability for treatment refusals while others allow a review board or a tribunal to overrule a capable refusal. Nova Scotia and Saskatchewan have raised the level of capability to what they call "fully capable."

Another solution is to allow a review board to overcome the capable refusal when it is likely to harm the person or others. Alberta and other provinces have done this. In New Brunswick, for example, they can overcome the refusal if "it is of the opinion that, without the treatment, the person would continue to be detained as an involuntary patient with no reasonable prospect of discharge." A similar model could be adopted in Ontario but would have to take into account—there's a famous case called *Fleming versus Reid* which said that you can only do these sorts of things if you give the person a hearing. It seems to me that if you follow what they suggest, you could do what's being done in those other provinces.

This is another serious issue which is alluded to in that paper that you've got: unnecessary detention, because the treatment stops when a person goes to court. This is in Ontario. Because the Health Care Consent Act requires treatment to stop when an appeal is before the courts, some people lose liberty for long periods during detention, because during the detention, they cannot be treated. For example, Professor Starson was incarcerated because he could not be treated for over five years while the court process slowly wound its way up to the Supreme Court of Canada—five years.

A study that I was involved in showed that people waiting for their court appeal from the review board spent an average of 253 days—that's eight months—in detention because they could not be treated. If it hadn't gone to the court, they probably would have been there three weeks or maybe a month, but they stayed there eight months on average. This contrasts with about a month, had they been treated. All patients' appeals were dismissed. So even though they waited for all that length of time, the court says, "Well, no, we don't agree with you," so they got treated anyway. How can such denial of liberty and treatment be considered justice?

There is in your act a way of issuing interim treatment orders, but they're very hard to come by, it would appear.

The solution in other provinces: In a number of provinces, this problem does not arise because appeals on

capability are not permitted. However, in Nova Scotia, which has provisions most similar to yours, they have solved the problem. This is the way they do it: "Where a matter is appealed to the Nova Scotia Court of Appeal pursuant to this section, the decision of the review board takes effect immediately unless the Court of Appeal grants a stay of any order made pursuant to this act..." In other words, authorized treatment continues unless the court says it cannot. It's the other way around here. As soon as you say, "I'm going to appeal to the court," it doesn't matter how ill or well you're doing; treatment has got to stop.

Let's then turn to community treatment orders, which are, I think, a very important innovation—well, not exactly an innovation; they're an innovation in Ontario, but they were originally introduced in Saskatchewan, and we have a similar scheme in BC. Community treatment orders—and I'm guessing that everybody knows roughly what I'm talking about—help many people stay in the community, out of hospital, and improve their quality of life. However, in Ontario, the previous hospitalization conditions limit the number of people who can benefit from this least restrictive measure.

CTOs are the least restrictive means of providing treatment for people who meet the involuntary admission criteria. However, in Ontario, in addition to meeting the in-patient criterion of bodily harm or deterioration, a person must have had, in the last three years, two admissions or 30 in-patient days in hospital. People who have had one admission, even though they meet the admission criteria—that's the in-patient admission criteria—cannot be put on a CTO. They may therefore stay longer in hospital and are more likely to relapse as a result.

Admission must be in Ontario. Even Mr. Arenburg—who some of you will remember, I'm sure—who, in essence, sparked the legislation that led to CTOs after he shot sportscaster Smith, could not be put on an Ontario CTO. This is because he had a number of psychiatric admissions before that awful incident, but they were outside the province so they didn't count.

Early psychosis programs in Ontario, if they are like those in Australia, have a small but significant number who could be released early and followed better on a CTO if the previous hospitalization precondition wasn't there.

The Ontario CTO is for people caught, in essence, in the revolving-door syndrome of doing well in hospital on treatment, being discharged, stopping treatment and being readmitted time after time. In Australia and New Zealand, CTOs are also used to prevent people from getting into the revolving door. In those countries, CTOs can be used instead of an in-patient admission.

Let's look at the solutions in other provinces and countries.

British Columbia, Alberta and other countries have addressed the problem. Australia and New Zealand use CTOs to avoid hospitalization; they use it on discharge as well. In BC, we have a one-admission rule. Alberta has

an equivalency series. So, for example, instead of having to be in a hospital, if you were in an institution like a prison, that would count. They still have preconditions, but if you qualify on enough of those, then you can be put on a CTO after your first admission. Critics, however, are likely to say that dropping "previous hospitalization" would drag people off the streets, like it did when CTOs were introduced previously. The experience of BC is that CTOs assist people to stay in their treatment, so they are less likely to become street people.

1730

Switching gears now from the Mental Health Act and the Health Care Consent Act to the information-sharing issues: Many authorities recommend including the family in case conferences and providing necessary information to them so they can assist their relative to get better, basically. Research on early intervention shows that family involvement is critical and, obviously, appropriate information must flow between the carers—the parent in this case, or the relatives—and the clinicians, and vice versa. However, according to your presenters, this does not seem to happen in some situations because of the Personal Health Information Protection Act.

But it's interesting that the purpose of that act is not just to guard information; it is to protect the information "while facilitating the effective provision of health care." From what I've read, it would appear that some people think it's very good at protecting information but not so good at facilitating health care.

The three areas that families—and I'm using the word "families" broadly speaking; it could be relatives or friends—usually want to be involved in are the collection, use and disclosure of information. Obviously, PHIPA prefers consumers to provide the information directly, and that's the way it should be. But oftentimes, with mental illness, the person is not in a position to provide timely or accurate information, so there is a provision that you have in your act that allows for indirect collection, but whether everybody knows about this, I'm not sure. Education may, in fact, be in order there.

There's apparently a problem where families want to be able to pick up the phone and report confidentially to the case worker that their daughter, for example, is not doing well, without having to seek permission from their daughter, who, let's say, is in a psychotic state. The mother wants assurances that the clinician will not tell the daughter who provided the information or what it is. This is because the family knows that if the daughter finds out that the mother provided the information, the daughter will be become very distraught, leave home unmedicated and get into all sorts of potential problems, become psychotic and have to be readmitted.

This confidentiality problem does appear to be at least partially met in the act under section 52 where it says that if giving access to the information "could reasonably be expected to ... lead to the identification of a person who provided information in the record to the custodian explicitly or implicitly in confidence if the custodian

considers it appropriate in the circumstances that the name of the person be kept confidential....” It talks about identity and it talks about the name; it seems to me, if you keep my name confidential, my son still might guess who gave the information, and it seems to me that’s not protected, although I don’t know the act well enough to be definitive.

Access by the patient to confidential or other information provided by a family can also be blocked if “granting the access could reasonably be expected to ... result in a risk of serious harm to the treatment or recovery of the individual or a risk of serious bodily harm to the individual or another person....” It seems to me that that is an issue that may not be known well enough, that if the information is likely to disturb the treatment planning, then it could be withheld. Certainly, people know about the one where physical danger might result from it.

It’s interesting, I just caught the last of the discussion by the information people, where it was said that bodily harm is interpreted under their act as psychological harm. They actually get that from the Supreme Court of Canada, out of the Criminal Code. But in BC it’s very explicit. In BC, it says that the information can be blocked, as it were, if it threatens “anyone else’s safety or mental or physical health.” So we’re on the same wavelength, but my comment would be, from knowing about mental health people, that they do not interpret bodily harm as including psychological harm. So you’d have to be very careful to make sure that if you’re going to use the same word to mean two things in two different acts, that people understand that. Personally, I agree with their suggestion that you change it to psychological harm or mental or physical, or something like that, but distinguish it from bodily.

On the use of information: In Ontario, if clinicians want to include families in their circle of care, it cannot be done because of the law, basically. The only way you could get that is if the person gave permission or they’re found incapable and then somebody else gives permission.

I want to deal with disclosure. Disclosure of information that families consider essential to providing care to their loved one or encouraging compliance with the care plan is a big issue that families have brought to this committee’s attention. Families want to be told by the clinician not just when there is a physical danger lurking around; the family member wants to know information essential to the treatment. They don’t want to know about the kid’s private life; they want to know things that are relevant to the treatment. That could include treatment issues, safety issues, signs of relapse, side effects to watch for, recovery plans to encourage, and so on.

Families also want information that is relevant even if the person is not physically living with them. Oftentimes, even though Bill is living in an apartment, mom is going down there every day or week to see how he’s doing, and she really is the caregiver.

In the PHIPA rules on disclosure to non-clinicians involved with care without consent, there are no provisions

except if there’s a physical danger. While some brave clinicians may provide families with information they think is necessary to enhancing the health care of the patient, these clinicians could also face a fine up to \$50,000. That encourages, I would think, a conservative attitude to information sharing. I think our fine is \$2,000 in BC. But I shouldn’t be flippant here; it shows how seriously you take privacy.

How does BC compare? The situation is really radically different in BC. Most of the time these things are pretty similar, but this is radically different. The act there recognizes that families must have information, without consent if necessary, to serve the needs of the client and to enhance their health care. The section reads thus:

“A public body may disclose personal information...:

“(a) for the purpose for which it was obtained or compiled or for a use consistent with that purpose.”

In your packages you’ll see I’ve given you an appendix out of the Mental Health Act guide. This is how it reads. This is our how our act is interpreted: “If a client’s personal information was collected for health care purposes, public bodies”—that’s your information custodian—“may release necessary information to third parties for ‘continuity of care’. This means public bodies may disclose personal information to health care professionals, family members, or to other persons, such as friends and relatives, involved in a client’s care for the purpose of that care”—unheard of, under your act. “The release of the information must be in the best interests of the health of the client,” and must be relevant and necessary and those sorts of things.

Adopting this BC approach would, I believe, address many of the complaints you’ve heard about families being asked to be responsible for care but not being provided with the information to do the job.

Another quick point about information sharing—and I don’t have this on a slide—is the interesting irony here of the public revelation of private information at review board public hearings. Despite the strong protection of privacy legislation in Ontario, if a person goes to a review board over a sensitive issue like the reasons for their committal or their capacity, that hearing is open to the public. In theory you could have a reporter there, you could have a mom there, you could have all sorts of people there. The chair has some discretion in keeping people out, but it’s seen to be a public forum. In all the other provinces it is not; it is seen as a private forum. In other words, the review board hearings in BC and Manitoba etc. are in private. Certainly, the chair can invite other people in, but the public does not have a right of access.

1740

Education and standardization: I just want to mention one of the tools that we found for helping educate people about these issues, and these are complicated issues. It’s very important to have sufficiently detailed but straightforward, ministry-blessed documents that people can relate to. Ours is called the Guide to the Mental Health

Act. Every ward has this. It's somewhat similar to yours, although yours is more complicated because you've got more acts to worry about. I think the big difference is that we have appendices in here specifically written for particular audiences. For example, we have one called, "Assistance from relatives and others in obtaining treatment." So if you're a mom or a dad, what are the sorts of things that you would look for in order to be able to convince the doctor or a judge that this person needs involuntary help? It's got one for police, physicians, and so on. I think it's fairly similar to yours, but it has those sort of personalized appendices. I think that could well be helpful.

Another idea that you might consider to help in education and standardization and also to assist consumers and families to get access to treatment when barriers such as implementation of legislation or insensitive practice prevents it is to have to have a treatment advocate. This is somebody who can help gain access to the system, basically, whether it's by overcoming legislative problems or access problems.

That's my last slide. I do have a few comments on implementation of change. If you recommend any changes, you'll find that people will oppose you, even if you say, "We just want to study them." My comment would be that all the changes that I've outlined to you, one of the concerns will be that they're not constitutional, that they would offend the charter. Each one of these ones that I've talked about has been passed by a Legislature, obviously passed by the AG of the particular government, and many of them have been approved by the courts as well.

I think what to do is what you're doing, which is, look at the problems; look at the options, including the ones that I've outlined and others; and look at what's happening in other countries. Look at the charter, because everything you do must be seen within the charter, and call it like it is. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Dr. Gray, for a great presentation. It was very thorough. We've got about 20 minutes left for questions. There may be a vote in there somewhere, so let's move quickly to questions, starting with Christine.

Mrs. Christine Elliott: Thank you very much. This is enormously helpful. I think I speak for all members of the committee: You've really addressed some of the very specific issues that we've been grappling with.

I'm just wondering, Dr. Gray, if you could just comment on the first admission. If we were to recommend changes to the Mental Health Act to allow for broader criteria for people to be admitted, would you recommend any changes in the form 1 as it presently exists, the 72 hours for that determination to be made? Where would we go then? Okay, the person's in hospital. What happens after that?

Dr. John Gray: You're talking about how long the certificate keeps the person in hospital for their observation period?

Mrs. Christine Elliott: Yes.

Dr. John Gray: It varies across the country, from 24 hours in Saskatchewan—we have 48 hours in BC. We

used to have a week, and then we brought it down. You have the 72 hours. I read somewhere that somebody wanted a week or whatever. I think that if you stretch it out too long, in essence, you're keeping a person in hospital against their will. It seems to me that the system should be responsive. Every day you keep somebody in hospital against their will is, in essence, a bad thing—a potentially good thing. But you need enough time for observations to be made. I think 24 hours is too short, but I think 48 to 72, something like that, is not unreasonable.

Mrs. Christine Elliott: During that time period, should a capacity determination be made as to whether the person has the mental capability to make those decisions or not? I notice you were talking about the substitute decision-maker presuming that the person has been found incapable in the first place. In Ontario, there doesn't seem to be that mechanism in the initial 72-hour period.

Dr. John Gray: To be honest, we don't use a capability assessment. In fact, in that first 48 hours that we have the person, we can treat that person. We don't have to sit around for three days waiting for him to get worse; we treat him.

I'm not sure exactly when your capability decision is made. I would imagine it's when the doctor says, "Look, I want to treat somebody with something," right? Whenever he or she gets around to that, then that raises the issue of whether the person is capable or not capable of making that decision. So it could be longer than three days. But I would suggest you do it as soon as you can. Every day counts.

Mrs. Christine Elliott: That seems to be the problem that we're hearing from families: The person may be able to come in and be initially "formed," as they say, and then the 72-hour period runs out and maybe they don't meet those criteria anymore, so then they're just discharged onto the street with no follow-up, no family contact, no nothing. Family members say that they don't know what they're doing. If they don't meet those initial criteria anymore, then there's nothing else that can be done. The question is whether there should be a capacity assessment at that point. If the person is deemed to be incapable, then that's when the substitute decision-maker can come in and start making decisions. But we don't seem to have that mechanism built in.

Dr. John Gray: But the decisions would only be, wouldn't they, on whether to treat or not, not whether to keep the person in? So if the person came in today and the doctor saw them, let's say, in 72 hours or whenever and said, "I don't think you meet the criteria," you're gone. And you couldn't even put the person on a CTO, because the person has to meet the in-patient criteria to be on a CTO.

Mrs. Christine Elliott: And then we end up with multiple hospitalizations again—

Dr. John Gray: That's right.

Mrs. Christine Elliott: —because then they keep coming back in. Is there anything you could suggest that we could think about that would allow us to deal with that particular issue?

Dr. John Gray: The major one is to have broader committal criteria. If you have a physical dangerousness committal criterion, people—often you'll bring somebody in and they're physically dangerous now, right? You treat them and in two days they're not, so you've got to let them go. But if you have a broader harm criterion, or a deterioration criterion that doesn't require a previous admission, you can say, "Look, if you're not treated, you're going to deteriorate, and I'm pretty sure you're going to be back here in a couple or three weeks. Therefore, I can keep you."

You see, the problem really is your committal criteria; they're too narrow. If the person comes in on broader committal criteria, you can keep them longer. But as soon as they're not dangerous, you have to let them go.

Mrs. Christine Elliott: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Okay. Without causing any offence, we have to go vote again. As I said, don't take it personally; it has nothing to do with what you've said. It has everything to do with us needing to vote. But if you'd excuse us for five or six minutes—

Dr. John Gray: Of course. I'm here all day tomorrow, if you want to stay.

The Chair (Mr. Kevin Daniel Flynn): Okay. I'm sure we'll think up some other questions on the way too.

Dr. John Gray: Good. Okay.

The Chair (Mr. Kevin Daniel Flynn): We're recessed for five minutes.

The committee recessed from 1744 to 1755.

The Chair (Mr. Kevin Daniel Flynn): Okay, if we can call it back to order.

Dr. Gray just finished answering some questions from Ms. Elliott. Are there any questions from this side? Helena.

Ms. Helena Jaczek: Thank you very much. In Ontario, we have a sort of two-step process. We have admission to the hospital and then we have the question of agreement to be treated. You state, in your brief to us, "In a number of provinces in Canada, where the purpose of the act is to treat, authority to admit involuntarily carries with it the authority to treat involuntarily." What would it take for us to get there?

Dr. John Gray: A major revolution.

Ms. Helena Jaczek: Yes. I was worried about that.

1800

Dr. John Gray: The provinces I was referring to are, specifically, Saskatchewan, where the person comes in, they meet the criteria and the physician authorizes the treatment—their treating physician. In Newfoundland and Labrador, it's the same thing. In British Columbia, the treating physician recommends to the director of the unit the treatment, and the director—this is where the person hasn't agreed to it themselves—authorizes the treatment.

The logic is that admission in those provinces is for the purpose of treatment; it's not just for containing dangerous behaviour. If it's for containing dangerous behaviour, that's what jails are for, and you should put people through the criminal justice system. The reason you have people in hospitals is because they're sick and

they need treatment. The Saskatchewan law commission had a beautiful comment that says that if there is no jurisdiction to treat the person in hospital, there's no jurisdiction to hold them there.

There are a number of provinces that do roughly what you do as well: They separate out admission from treatment. Australia doesn't, New Zealand doesn't and various other places as well.

How would you change it? I think you just have to argue that it is wrong to admit people just for the purpose of containing behaviour and not for the purpose of treatment. And if, like our court said, the purpose—it's clear in the BC act that the purpose is to treat people, and if you can't do it, then don't admit them.

Ms. Helena Jaczek: Let me just follow up. When we had the Ministry of Health legal counsel here, talking about PHIPA and consent to treatment—actually, when she was talking about consent to treatment, she made the analogy that if someone is admitted unconscious, there is an assumption that they would consent if they were conscious. And it strikes me, as I've listened to so many of the stories we've heard over the last nine months, that, essentially, someone in a psychotic state is almost like that unconscious person. I mean, they literally—they may be sitting up and walking around, but they are not consciously able to give consent. I suppose—the legal counsel immediately admitted that it was sort of obvious that they would assume if they were conscious. Well, I seem to see a very parallel situation here when someone is in an acute psychotic state. Is there any way to make that parallel?

Dr. John Gray: Let me make one point just before that. We are talking here about consent to treatment, and people would say, "Well, if you went to the doctor, you would have to give consent to the doctor to treat you." They analogize that to the involuntary in-patient. But in fact, you also have to give permission to be admitted. If somebody just admits you—you know, grabs you and takes you into Toronto General Hospital—that's false imprisonment and all those things. So there are two issues.

But under a mental health act, you're admitted without your consent, right? That's the reason you have a mental health act, otherwise you wouldn't need a mental health act. You're admitted without your consent. So the argument that I make is that, in the same way, you must be treated without consent in order to get you out of hospital. There's no other way of getting you out.

How do you make it parallel with the unconscious? You see, the trouble with that analogy, I think, is that if the unconscious person had in their wallet an advance directive that said, "Please do not revive me," you'd be bound by that under your laws—under everybody's laws, actually. So I'm not quite sure how you analogize those.

The Chair (Mr. Kevin Daniel Flynn): Okay, first Jeff, then Howard, then Liz. Jeff?

Mr. Jeff Leal: Dr. Gray, thank you for a most insightful presentation this afternoon. I have a quick question and then an observation. How long have the changes been employed in British Columbia, and what

was the catalyst to make these, what I would say, very significant changes?

Dr. John Gray: The last set of significant changes were made in 1999, but they weren't that significant, really, because we always had a broad, broad committal criteria. It was called protection against harms, which is pretty broad. We brought in the deterioration and changed the words a bit. We also strengthened the rights aspect of CTOs, or our equivalent thereof. That was 1990. The changes came from a lot of pressure from coroners, from the schizophrenia society; opposition came from legal rights people, a little bit from CMHA, but not a huge amount.

Mr. Jeff Leal: Over the last nine months, people have shown incredible courage to come before this committee to share very personal stories. I think one of the common themes there is that the families become isolated and then estranged from many of their loved ones who have mental illness. It seems to me that some of the suggestions that you've brought forward today would break down both the isolation and the estrangement that people find when their families and their loved ones—if you could comment on that.

Dr. John Gray: I think that's true. It's interesting, for example, that our BC act encourages more, I think, interaction between clinicians, clients and family members, which is a helpful thing that way. The families don't get into the situation where they have to agree with or disagree with the doctor on treatment because the family is not involved; it's done by the hospital.

Another interesting issue that people have talked to me about here is involving the courts. When you can't get the doctor to see the person, then you have to go to the courts. Somebody was just telling me about how their daughter got dragged in with handcuffs, and that sort of thing. For whatever reason, in BC, I know of about three cases in all the years I've been there where the courts have been involved. Whether our doctors are good out there or whether our teams are, I'm not quite sure which. But if you don't have those sorts of things, they can be very alienating.

I think getting people better quicker will also help, because it's oftentimes that there's a good family situation, and then the son or the daughter becomes ill, they hate mom, and mom gets blamed in part for the delusions. And when they get treated they come back and think, "Good Lord." So I think that the emphasis on treatment can be helpful on that.

Mr. Jeff Leal: Thank you very much, sir.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Jeff. Howard?

Mr. Howard Hampton: I've got a couple of general questions. You alluded to one of them earlier when you said that British Columbia—I believe you said 1999 was when some of the amendments were made to the mental health legislation. What about Saskatchewan and Manitoba? Do you know?

Dr. John Gray: Saskatchewan was before that. I don't know the exact dates—it would probably be in the 1980s or early 1990s. What they did is, they were the

first province to bring in community treatment orders. They're actually more restrictive than yours. They also brought in the deterioration criteria that we talked about. They were the first to do that. Those were the major issues.

Mr. Howard Hampton: How about Manitoba?

Dr. John Gray: Manitoba was a bit after that, I think. Some of these issues have been driven by—somebody asked before about the motivation of why these things got going. Sometimes it's been because of regular pressure—I should have mentioned that coroners and police were very much in favour of ours—and sometimes there's been a tragedy, like the Brian Smith situation here.

In Alberta, they have just changed their laws. They had very close dangerousness laws just like yours—in fact, more tight than yours—and they have just brought in what basically everybody else has got. They did that because a guy who had been in hospital—they knew he was dangerous, but under their criteria, which was so tight, they had to let him out and he shot a Mountie. That was not received well, and that sparked a whole review of their mental health act. Now they have CTOs as well.

Mr. Howard Hampton: This is mainly a historical question. There's always been a contest here: the legal rights of the patient versus the likelihood of beneficial treatment. In reading your paper, you essentially say, I believe, that Ontario has followed the US model.

Dr. John Gray: Yes.

Mr. Howard Hampton: How do you account for this? Ontario going in one direction, most other Canadian provinces ending up somewhere else?

Dr. John Gray: I don't really know. I know that Alberta was, as I said, just until this last year, very similar to Ontario. My guess is that there's more of a north-south dialogue of ideas, whereas in BC there wasn't. There are a lot of lawyers who are very strong civil rights folks, and that whole civil rights movement in the States was attuned to them. So when you talked about changes in your act up here, it was those ideas that became dominant. But I don't have the specific details.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Dr. Gray. The final question for the afternoon goes to Liz.

Mrs. Liz Sandals: You began talking to us about mental illnesses that affect insight, where there isn't sufficient insight to understand that you require treatment, which I found a really interesting comment. From a legal perspective, do we need to deal with that, or do we simply need to deal with sorting out the definition of harm so that we're simply dealing generally with serious harm and deterioration—and if we take care of that from a legal perspective, the lack of insight will take care of itself?

Dr. John Gray: I would say that the latter is appropriate. In other words, the reason the person is there is because they wouldn't voluntarily come. There are very few people who come to hospital who agree that they're as ill as you think they are. Almost everybody who gets into an involuntary situation has an insight problem—

even though not everybody with schizophrenia, for example, has an insight problem. Those people with schizophrenia could be quite serious but don't have an insight problem. They'll say, "Yes, there's something funny going on here. I'll take those pills that you want me to take," and they'll get better.

Just to get back to your question, I don't think you're going to change the way you do approval of treatment. It's in the Health Care Consent Act; it's everywhere, so I think it would be a huge job to change it. Still, if there were a few changes made—changing the fact that you can't, when you're apparently competent, say, "Look, I don't want any of that medication," and then your mom having to go along with it and seeing you in hospital for longer periods of time. Use it, but have the override they've got in Nova Scotia and Manitoba. If somebody does go to the review board, the hearings have to be done within seven days. That's a bit long to keep somebody in hospital, but it's not completely unreasonable. The business of when treatment must stop while the court gets itself sorted out, which might be months or years, is unreasonable.

So I think that there are a few—they're not to my mind—

Mrs. Liz Sandals: If we take care of the other stuff, that issue will be taken care of by—we don't need to get into medical definitions?

Dr. John Gray: No. The definition of a mental disorder in your act is very broad. It just says, "any disease or disorder of the mind." Most of the rest of us have fairly detailed ones at the moment. I don't think it matters that much, because you've got other things that reduce the likelihood of the person being admitted.

Mrs. Liz Sandals: Thank you very much. This has been very, very helpful.

The Chair (Mr. Kevin Daniel Flynn): Dr. Gray, on behalf of the committee, thank you very much for coming all the way from BC. I think your report was just what the committee was looking for, and it was very clear.

Just for the members of the committee, the next meetings of this committee will be in 2010: February 1 and February 8 for report writing, so they will both be in closed session.

We're adjourned. Thank you.

The committee adjourned at 1810.

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Mental Health
and Addictions Strategy

Chair: Kevin Daniel Flynn
Clerk: Susan Sourial

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Deuxième session, 39^e législature

Journal des débats (Hansard)

Mercredi 24 mars 2010

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SELECT COMMITTEE ON
MENTAL HEALTH AND ADDICTIONSCOMITÉ SPÉCIAL DE LA SANTÉ
MENTALE ET DES DÉPENDANCES

Wednesday 24 March 2010

Mercredi 24 mars 2010

The committee met at 1631 in committee room 1, following a closed session.

MENTAL HEALTH AND
ADDICTIONS STRATEGYONTARIO PROBLEM GAMBLING
RESEARCH CENTRE

The Chair (Mr. Kevin Daniel Flynn): If we can come to order, we've got the Ontario Problem Gambling Research Centre: Judith Glynn and colleague. If you would introduce yourselves for Hansard, that would be great, and then we've got you until about a quarter after five.

Ms. Judith Glynn: What I'll try to do is keep the presentation to about 20 to 25 minutes so you can ask questions at the end, but it may go a little longer.

Thank you very much, Ms. Sandals and committee, for inviting us here today. My name is Judith Glynn. I'm the director of operations with the Problem Gambling Research Centre. I'm here with the chair of our board of directors, Lynda Hessey. Just as a piece of information, Janine Robinson, who is here from the Centre for Addiction and Mental Health and will present after me, and I have tried to coordinate our content. Between the two of us, our plan is that we will give you a comprehensive initial understanding of problem gambling, and then of course we're available for any questions.

The other thing is that I did not print copies of the presentation, but I can make any of this information available to you afterward—any reduced version thereof—so just let me know.

I'm going to focus on what the research has told us, or what we know about problem gambling based on the research, and then Janine will speak more specifically about treatment and the treatment system here in Ontario. I'm hoping that's a good division of information and allows you to catch your breath a little bit.

Gambling means risking something of value. If you can imagine, I had a call from three reporters in the last week wanting me to comment on Roll up the Rim. I said it's just not gambling. I mean, you're getting your cup of coffee.

Interjection.

Ms. Judith Glynn: You won. The idea of gambling is that you're putting something of value to you at risk on a chance outcome and on the chance that you will get more than you put at risk. In terms of participation rates, we've

seen them kind of stabilize in Ontario over the last few years. We had high rates when gambling was first expanded maybe 10 or 15 years ago, in the 1980s. We now have participation rates that have stabilized around 63% of the population. You can see that the predominant form of gambling is lottery tickets, but about 23% of the population regularly goes to casinos or plays slot machines. Those figures are probably quite stable.

Of course those rates are higher among young adults, as many of you might know from your own young adults, particularly the rate of online gambling. Very quickly, among young adults we're looking at a variety of vehicles for gambling, now including cell phones. The rates that you see rising from 2001 to 2005 have probably increased quite substantially since then; we just haven't assessed prevalence since 2005. But you can also see that the types of games they're playing are different and they're playing frequently.

In terms of problem gambling, there are many definitions out there, but basically we're looking at gambling where someone is excessively involved in the activity. They're spending more time and money than they can afford, and they're suffering negative consequences. It's usually a combination of those two things: The behaviour is out of control or in excess, and there are consequences. In terms of problem gambling, if we use the latest prevalent study, we're looking at about 3.8% of the population with a moderate to severe gambling problem. That's fairly stable across the country—some provincial variation, but that's not unusual. Again, you see that young adult population with the highest rate of problem gambling. Interestingly, one in 10 people report that they have personally been negatively affected by someone else's gambling.

In terms of those negative consequences, the most common one is clearly financial difficulty. Just by the nature of the activity they're engaging in, that shouldn't surprise any of us. Relationship conflict is, of course, equally understandable. The co-occurring mental health issues are quite startling if you've never seen them before: 20% of problem gamblers will attempt suicide, and 15% to 24% of them have a lifetime history of clinical depression. That is definitely a worry, and then there are impacts on work and school and, less commonly, resulting physical health impacts and criminal activity.

Just quickly, I wanted to give you a picture. If you don't know a lot about gambling in Ontario, this is the

complex map of the players. I have copies of this if anyone wants it afterwards. You can see that the blue column is the regulatory function. There's the operational function and harm minimization, and government oversight across the top. So you have a number of government ministries involved in the regulation, operation and minimization of harm related to gambling. "You are here" is the Ontario Problem Gambling Research Centre. We're fully funded by the Ministry of Health and Long-Term Care. You can see there are some private sector relationships in there, in terms of the delivery of gambling. So this gives you a good sense of who all the players are in this complex world of gambling in Ontario.

1640

The way I'm going to discuss what we know about the research is using a model that I suspect you've all seen, because you're dealing with mental health. This is sort of the dominant model for addiction, the bio-psycho-social model. It's sort of widely understood now that addiction is the result of a complex interaction of these factors. As you'll see as I go through some of the information, they're very much intertwined. Many of the psychological factors are genetically or biologically derived, and some of the social-environmental factors are hard to disentangle from genetic factors, like parental gambling. We'll just look into each of these areas, and what I'm going to give you is the research that is quite solid. This is information where we have research evidence to say, "This is the case." It doesn't mean there isn't more out there; we just don't have the research to confirm it. At the end, I'll talk about how we can address that.

If we start with our biology, because that's where it all begins, we look at what we know about the genetic predisposition for gambling. The genes they're looking at, not surprisingly, are the same alleles they look at for other addictions. They have found some commonalities; in particular, the genes that are associated with dopamine—dopamine receptors—and then those other elements of that transmitter reward system in our brains: serotonin and norepinephrine.

Basically, what's happening here is that these are the reward and inhibitory systems, and they don't work as well in problem gamblers as they do in the rest of us. So it's not surprising that these are the genes they are examining. It's a complex area of research, but as this research continues to grow, we will see that there are ways to at least account for some of the variance in gambling problems by looking at these genetic factors. Then we'll look at some of the neurobiological factors, which are very closely connected. So you have those genes that are responsible for the dopamine receptors and that kind of thing, and then you go into what's going on in terms of our neurocircuitry. It's not surprising that what we're looking at, again, are those reward systems and what's happening.

We have research showing that in a problem gambler, sometimes the pleasure centre in the brain is bigger and the inhibitory sensor is smaller. So not only are they getting more bang out of the activity, but they have less

of a stop signal that is going on and telling them to slow down. Some studies have shown that activity related to dopamine is different in problem gamblers from the way it works in normal controls. The interesting thing—this is where it gets hard to disentangle—is that as any addiction progresses, there are changes in that neurocircuitry. So some of it may be accounted for by the genetic predisposition, but as a person becomes addicted, they actually change those neuroprocesses. That's why some addictions are so difficult to address.

Again, there is a variety of these neurotransmitters that have been associated with problem gambling. If we go into the psychological area—I think I'm going to do that one last—this is the group of psychological factors that is most strongly associated with problem gambling. You probably won't find this surprising: 75% of problem gamblers smoke—that's dramatically higher than the general population—25% with alcohol abuse and 20% with other drug abuse. But even those rarer addictions, like sex addictions, are disproportionately represented in problem gamblers. So we know there is increasing evidence, with the combination of genetic and neurobiological information, that there is some kind of tendency to addiction, and we're seeing that in problem gambling as well as in other addictions.

The other issue I'll talk about a bit later that is difficult to disentangle is the causal or temporal order of these things: Did those other addictions come first; did they cause the problem gambling, or are they all caused by those same genetic and biological factors? Some of that information we don't know yet.

What is particularly useful with gambling as a form of addiction is—you've probably heard a little bit about operant and classical conditioning in your hearings; am I right or wrong? Classical conditioning, if I understand it correctly—it's Pavlov's dogs: If you hear the bell, you're going to get meat, right? So you start to salivate. Operant conditioning is where you hear the bell and you might get meat, so you salivate anyway and you keep trying and trying. This is the rats that got cocaine, and they kept pushing the lever and pushing the lever. In fact, when the frequency of reward was variable rather than predictable, the process of addiction was faster and harder to extinguish. The most potent form of addiction is when you have a variable and high frequency of reinforcement, and we definitely have that with many forms of gambling.

In terms of other mental health disorders, again, these figures are fairly surprising. Problem gambling is strongly correlated with just about any other mental health disorder you can come up with. The mood disorders particularly: This is probably the area where the most research has been done. There's a very strong correlation between depression, anxiety and problem gambling. But even in those impulse disorders—and problem gambling is often considered an impulse control disorder—you again see this correlation between obsessive compulsive disorder, bulimia and those characteristics that are related to impulse disorders, like just simple impulsivity, ADHD or a high need for sensation.

All of these things are strongly correlated with problem gambling.

Then you get into those personality disorders: borderline personality disorder, anti-social personality disorder. You do see a correlation, but not only that: As the problem gambling severity increases, the number of co-occurring personality disorders grows. So they're really in a mess. All these mental health disorders are probable risk factors for problem gambling.

Quickly, I'm going to look at another area of the psychological, which is the cognition. This is really related to how the human brain understands gambling. I don't know if any of you read Steven Pinker, but he basically says that if we were able to understand the repeat randomness that occurs in a slot machine, we would never have survived as a species, because as a species, we have learned that we must guard our actions based on the learning from past events. You have to throw that out completely when it comes to a slot machine. You can play for 10 hours straight, lose every penny you've got, and there is no greater likelihood that the next play is going to be the winning play. That's what's very difficult for any human brain to grasp and particularly intransigent for people with gambling problems.

We have strong evidence that this illusion of control is strongly correlated with problem gambling. They overestimate their chances of winning, they overestimate the element of skill involved and they overestimate their control over the outcome. We do have some evidence that those cognitive errors are then further reinforced by the characteristics of the machine. So if they see a lot of near misses, if they see a "stop" button, they think they can press it at just the right moment to get the win. These things can feed into the cognitive error that can lead to the gambling problem.

The other thing that reinforces our understanding of this is that when treatment addresses those cognitions, it tends to be more successful. So we do know that cognitive error is a big factor in the development of gambling problems.

Now we'll go over to the social-environmental area. In some ways, this might be more interesting, just from a policy perspective. Let's start small. From family, we'll move up to culture and then into the broader social environment.

Not surprisingly, there is increased risk of poor mental health in the children of problem gamblers. Children of problem gamblers have a higher risk of developing a gambling problem themselves. There is some research that disentangles the genetic predisposition from the modelling, and it appears that both are playing a role in the development of problem gambling in children. Then you have those indicators that are strong indicators, probably, for many mental health disorders that you've been looking at, and those are lower income, being a member of an at-risk socio-economic status group and having any kind of abuse and neglect in your upbringing. These all seem to be predisposing factors to lead children to develop gambling problems.

We'll look at the culture and peer group. There's a lot of information here. I've tried to condense it.

What we know is that in international prevalence studies—a number of studies in a number of jurisdictions in the world—ethnocultural minorities have higher rates of problem gambling. It doesn't matter what colour they are or what ethnocultural group they belong to: If they are a minority, their rate of problem gambling is higher. Then we know that in Ontario, these ethnocultural minority groups—at least the ones which have been studied—do show evidence of higher rates of gambling. Normally, higher rates of gambling mean higher rates of problem gambling. The challenge here is getting a large enough sample size, one that's been randomly selected and is representative of that subpopulation, to confirm it. So we do have a strong sense that problem gambling is existing at a higher rate within those ethnocultural populations.

1650

In certain populations which have been studied here in Ontario, you see that: aboriginal, Chinese, Italian and Russian. They all show higher rates of gambling. There are other populations where there probably is more research needed to understand whether or not, culturally, gambling is a big factor or simply if the factor of being a minority in the population is playing a role here.

If we just step outside of culture, the other piece of that is peer group involvement. When young adults or young people have peers who are modelling gambling behaviour, not surprisingly, they're far more likely to engage in it. So it is a significant risk factor for children and young adults.

Then we'll look at the broader environment. This is the kind of social context in which gambling takes place. I've broken it up into a number of things, starting here with what types of gambling we know are most strongly associated with problem gambling.

I'm sure you all heard, 15 years ago, the quote that was all over the Star and other media that VLTs are "the crack cocaine of gambling." The evidence on electronic gaming machines is really interesting. I talked to you a little earlier about that variable, high-frequency reinforcement schedule; you definitely have that in electronic gaming machines. Electronic gaming machines have been shown to be most strongly correlated with gambling problems in several countries: in North America and throughout Europe. Definitely, electronic gaming machines are the most strongly correlated, among all forms of gambling, with the development of gambling problems.

However, in some Asian countries where they didn't have slot machines for the last 100 years and where other forms of gambling are more culturally popular, the forms of gambling that offer that variable high frequency—and some casino table games, in fact a number of them, offer that kind of reinforcement schedule—are the most strongly correlated with problems. So what we know is that it's that high-frequency variable reinforcement schedule that seems to be the culprit. Regardless of

what's happening in the rest of the world, in North America it is EGMs that are the greatest source of problems.

You have a few specific pieces of information here related to things like the "stop" button: There is research that shows that if there is a "stop" button, people will play for longer. I don't know why they persist for longer, but they do. If they're shown more near misses than would happen by pure chance, again, they will play longer in the session.

I want to talk a little bit about the issue of access. There's lots of debate on whether increasing the availability of gambling—the number of venues, the number of opportunities—is correlated with gambling problems. To their credit, the research community has tried to disentangle this. It appears that it is not simply the quantity of gambling that's out there, it really seems to be proximity; so the more gambling venues you have and the more you disperse gambling throughout the community, the higher your rates of prevalence of problem gambling are going to be, because more people—people like to gamble close to home. Problem gamblers gamble close to home. The proximity of gambling opportunities is definitely strongly correlated with the development of gambling problems.

That Ladouceur study, by the way, in Quebec, did a repeat design: he conducted his study and then, after new venues were added, conducted the same study and found a 75% higher number of problem gamblers. So we do know that this issue of access and proximity has some strong research evidence.

Advertising, marketing and promotion: You probably hear a lot about whether or not this is a factor in the development of gambling problems. There is not really strong research evidence yet. In fact, the evidence to date seems to suggest that it's not a strong effect. It may be a weak effect, because if you look at jurisdictions with restrictions on advertising, they don't have different prevalence rates from jurisdictions which have fairly wide open advertising available.

There is some qualitative research that shows that advertising for gambling does serve as a particular cue or trigger to problem gamblers, so they seem to notice the ads more, they seem to be cued more to gamble, they express more often desire to gamble when they see ads related to gambling. While the level of advertising, marketing and promotion may not be affecting prevalence rates in a society, it may be serving as a stronger cue to problem gamblers.

The other idea that has been posited is that what the advertising, marketing and promotion of gambling does on the larger social level is just influence social norms, so you have an increased acceptance of gambling, maybe more provision of it, perhaps loosened regulation of it. So the influence of gambling is weak in terms of prevalence, probably occurring at a higher level, and then at that micro-level with the problem gambler as a cue.

Responsible gambling programs, on the other hand—there is some fairly strong evidence that when you

introduce pretty strict limits on people's ability to gamble too much in one day, or gamble too frequently in one month, you do see reduced prevalence. So in these countries that I've indicated here—Norway, Germany, Netherlands—you see much lower prevalence rates of problem gambling—0.4%, 0.6% and 0.5%, versus 3.2% in Canada. That's a dramatic difference.

You can't strictly account for that by these responsible gambling programs. There are different cultures, different societies, there are a lot of factors that are probably at play, but they have very strict requirements on operators to detect the presence of a gambling problem and to exclude.

In Germany, for example, the operator is legally obligated to detect problem gamblers and to exclude them, so you have much more sophisticated player tracking systems. You have much more going on in terms of helping people not to develop gambling problems.

In, I believe, Norway, if you suddenly double your participation at the casino, then you're asked to sit down for a meeting. If your rate goes up more than, I think, four times a month, then you're asked to meet with someone. They have a number of things that they do that are designed to detect early, intervene and prevent further development of gambling problems. It does seem to be making a difference, and the big test of that is the fact that Holland did see a decrease in their prevalence rate once they introduced some stricter responsible gambling programs.

Interjection.

Ms. Judith Glynn: What was that?

Ms. Sylvia Jones: It's now 0.5%. What was it?

Ms. Judith Glynn: I can't remember. I'll have to get that for you.

That's kind of the spectrum of factors that are contributing to the development of gambling problems. I'm going to just quickly show you which risk factors have the strongest research evidence. This doesn't mean they're the strongest risk factors, but there is the most research to clearly demonstrate that these are risk factors.

You can see, some of these are things that can be modified and some of them can't. We can't change someone's gender, their age, their ethnocultural origin; we can't really even necessarily change parental gambling. When you look at these risk factors, I'm going to quickly talk about what we can and can't do with those that are modifiable and those that are non-modifiable, but basically, these are the ones where there is the strongest research evidence that they play a role in the development of gambling problems.

We have those demographic characteristics: the role of parental gambling, the proximity to gambling venues, those erroneous cognitions, the type of game, addictions—very strongly predictive of gambling problems—other mental health disorders, and delinquency and criminal history—very strongly predictive of gambling problems.

So what do we do? For those non-modifiable risk factors, we can't change the risk factor, but as a society

there are things we can do. We can have protection policies that are particularly aimed at at-risk populations; for example, our restrictions on underage gambling. That's an example of protection policies.

We can have education generally to the target population and the public about particular populations being able to identify themselves as being at-risk and what they should do about it. Then we can have detection and identification of those populations, we can increase early intervention, and finally—Janine will talk about this more—we can customize treatment to those particular populations, whether they're a demographic age group or an ethnocultural group.

1700

With the modifiable risk factors, the first thing you can think of is, should we just change the policy or the practice? Of course, that's ultimately where you want to get to, that question. But there are some things, from a research perspective, that I think you need to do first. In some cases, those factors—we need to confirm that risk factor and we need to confirm how strongly it's contributing to gambling problems, but, realistically, as policy-makers, you should also know what the impact of that risk factor is on game enjoyment, and then what the economic impact of modifying the risk factor is.

For example, I presented a framework a year ago that asked: So what do you do if you know that certain features of a machine are associated with harm? Well, you need to know how strongly it's associated with harm, you need to know how strongly it's contributing to enjoyment for the non-problem gamblers, and then you need to know the economic impact of removing the feature or changing it. Then you're in a position to make a policy decision. So, in terms of those modifiable risk factors, in some cases we have this information; in other cases we don't.

My final slide is just going to be where we might go from here in terms of the research to provide you with more information to answer those important policy questions.

One of the things that we don't really understand yet is, we have this configuration of risk factors. We know they interact. We don't know the relative contribution of each one. So if you asked me, "Which one should I focus the most resources and energy on?" it would be a debate. I might be able to pull on some research, someone else might draw on other research, but we really don't know the relative contribution of these different risk factors. Those findings, in many cases, were found in laboratory settings. We need them to be confirmed in a naturalistic or a real gambling setting, and we need those longitudinal perspective studies, because what those will do is help us to disentangle the relationships among these risk factors.

I kind of alluded earlier to the fact that in terms of many of those risk factors, like the addictions and the co-occurring mental health disorders, there are probably three different pathways or routes that are being taken. So in some cases that risk factor is indeed causing the

gambling problem. In some cases, the depression, the criminality—whatever the co-occurring issue is—and the problem gambling have common roots. They're not causing each other; they are both caused by the same set of other factors. And then, finally, problem gambling can be causing things like depression, anxiety, some of those physical health issues. So what we need is the kind of research that will continue to help us disentangle those roots, and that will put us in a better position to understand exactly where we need to put resources and our emphasis.

That's my overview. If you have questions—

The Chair (Mr. Kevin Daniel Flynn): Do you want questions now or do you want us to hear from the next speaker and then—

Ms. Judith Glynn: I was going to suggest that. I didn't know if that would be too bold. But if you're okay with two presentations in a row, and then Janine and I can just field the questions—that works?

The Chair (Mr. Kevin Daniel Flynn): Yes, that works.

PROBLEM GAMBLING INSTITUTE OF ONTARIO, CENTRE FOR ADDICTION AND MENTAL HEALTH

The Chair (Mr. Kevin Daniel Flynn): We're a little bit ahead of schedule, so don't panic.

Interjections.

The Chair (Mr. Kevin Daniel Flynn): Go right ahead. We're all yours.

Ms. Janine Robinson: Can everyone hear me all right?

My name is Janine Robinson. I'm an addiction trainer and a therapist. I've been specializing in problem gambling for the last 11 years now, working with people across the province who provide counselling services to people affected by problem gambling and their family members, and also actually counselling people. I'm located here in Toronto, just down the street at the Centre for Addiction and Mental Health.

We've just rebranded ourselves and aligned our services and programs to be a little more streamlined in what we do. We're now calling ourselves the Problem Gambling Institute of Ontario at the Centre for Addiction and Mental Health.

In the time that I've been in the field—and one of the things that I want to encourage us to remember when we're talking about this whole gambling thing is how new the field is compared to substance abuse, compared to tobacco. It's still very young, so a lot of the research needs that my colleague pointed out are absolutely legitimate. At the same time, for such a young field, we know so much in this province compared to some other jurisdictions in the world. We're really well situated in this province to make some really informed decisions about where we go next with gambling in Ontario.

My areas of interest, since I started doing this work, have always been around cultural influences on people's

decisions, on their knowledge systems and how they decide to play which games, and how they interact with the actual gambling itself. I know a lot about culture and problem gambling, and it's something that has always been interesting to me.

I'm also interested in the games themselves. Right now, for example, I'm studying poker. Everyone here, I'm sure, knows that the craze of poker has just swept, and continues to sweep, North America; it just seems relentless. In our agency, where we see hundreds and hundreds of clients a year, poker clients are surfacing in very low numbers. I've been very interested in what it is about the way we offer help to people that maybe isn't suitable for poker players, isn't hitting them, isn't making sense for them—some of the dynamics or the culture of the game and the culture of the players and whatnot. That's one of the things I'm studying right now, for example.

I also have been involved in working with the OLG as a trainer and consultant around content for them to work with their staff in the gaming environment to get to patrons in the gaming venue while they are having problems. I've been doing that for quite some time now. It's very interesting work.

So I can speak to all those areas with some level of authority.

1710

I'm just going to acquaint you with the Problem Gambling Institute of Ontario. We have a provincial mandate. We are one of the four provincial partners that Judith Glynn showed in the far right column of her chart there. We provide treatment services, outpatient counselling, telecounselling. We're developing online materials to support people who have problems with gambling. We develop professional education and community resources. Everyone has a handbook in front of them, the orange one: *The Issues, the Options*. We've developed handbooks for allied professionals—bankruptcy trustees, people who are in seemingly unlikely positions to identify people with gambling problems, but if you think about gambling and money, the bankruptcy trustee connection has actually been a very useful alliance for us to get people support who are dealing with financial issues of bankruptcy.

We provide research. Some of that at least, if not much of it, is funded by the Ontario Problem Gambling Research Centre. We are also provincially responsible for communication and information dissemination. We're currently calling it knowledge exchange or knowledge transfer. Our role with the research centre, for example, would be to take current findings and help translate them into clinical practice. So if the current finding is that young Chinese men are experiencing higher levels of problem gambling than someone else, it's our role to take that information and do something with it that's helpful and gets to the actual client need.

Our funding for problem gambling treatment, I'm sure you know, has come from 2% of charity slot machine revenue. Does everyone know this? Yes? That's one of

the positives, I think, of our field being so young. If we had a similar situation with substance—a penny off of every bottle of beer that was sold—the treatment system would be much better resourced than it is today. This has been a very strong and positive situation, having this funding, and it's ongoing, early implementation. It's vital to us being effective provincially.

Gambling is very big business in Canada. In 2008, over \$13 billion was the net revenue from gambling. It's Canada's largest entertainment industry and it's approximately the same as television, recorded music and professional sports combined. That's just staggering to think of. That is big, big, big business. When we think about it—I'm seeing most of the people in the room are over 30—in our lifetimes, we've gone from having gambling be considered in this province as something really on the outskirts of our moral acceptance to grudgingly accepted—Las Vegas, the crooner era—to being promoted and linked to positive virtues.

When I was training to become a problem gambling counsellor I had in my mind that I was going to treat Frank Sinatra or Dean Martin. I did. I had this stereotype that this is the type of person I was going to be treating, and I've treated some people like that. But I didn't have in my mind that I was going to be treating grandmothers. It didn't really cross my mind that a large percentage of my caseload of people who were in distress were going to be in retirement years—grandparents. Our culture shift has changed so dramatically that now casinos are a nice place for grandma to go and have an outing. Just in my lifetime, the shift has been just astounding around how we've accepted and changed our views about gambling.

Promotion: over \$2 billion every year in the nation; very large money.

In our province—Judith already touched on this—about 63% of Ontarians gamble. The electronic gaming machines—the slot machines—are the most problematic. The fact that Ontario has no video lottery terminals in corner pubs, in venues like that, is a real source of relief to us. It has been associated with some really high problem rates in other provinces, and clinicians I work with who are in the border cities like Ottawa, or who work on the border with the States—Sault Ste. Marie, for example. People who work in those regions tell me really in an unqualified manner to tell you that we're glad there are no VLTs in the province. I'm just passing that message along.

In the north, a lot of the games that will be played will be quite different than in some of the regions. In the north there's going to be a bigger emphasis on card games than there might be in some regions, and that's largely due to the lack of casinos in remote areas. There might be more women playing poker; there are, in fact, more women playing poker than there would be in the south. Bingo is big. Do people know what Nevada tickets are? Okay. Near large urban centres, we have casino-based gaming, so the large casinos in Niagara Falls, Windsor, Orillia, Rama—Mnjikaning First Nation—those areas. Then there are also the smaller slot venues

that you can see on the blue signs across the province. Next time you drive from Sarnia to wherever—London, Toronto, North Bay—count the signs as you go by. Look at it as if you're a tourist to the province and see how many charity casino signs you see on the way. It really is fascinating.

These are the games you can play if you live in a large urban centre, and if you live in a semi-rural place like just outside of Barrie, there's the racetrack. We're calling them "racinos." There are racetracks and they're attached to slot machine venues, so those two businesses have supported each other and, in fact, adding the slot machines to the racetracks really saved the industry. You can get those everywhere and anywhere.

If you have a BlackBerry or a cell phone or a computer, you can of course gamble online. There are all kinds of online gambling to do. I just named some of the more prevalent ones. In Ontario—oh gosh. I think I have it later—I can't remember the man's name now. Duncan—

Ms. Judith Glynn: Paul Godfrey.

Ms. Janine Robinson: Thank you. Paul Godfrey just recently expressed an interest in Ontario joining the online gaming business.

This is from this week. I was trying to find out for you how many people have called the Ontario Problem Gambling Helpline, now known as ConnexOntario, to discuss slot machine problems, because that is by far the number one.

That is a direct quote from that correspondence: "Out of the 1,567 people who called regarding their own concerns with problem gambling during fiscal year 2008-09, 1,144 reported problems with slots"—astronomical and not inconsistent with any other year, as far as I can see. It seems very consistent. You have a stats page, a little two-pager, there. That's the one. That quote and the contact person is there. There are also some other relevant statistics and if you want to follow up about any of these, you can find that there.

I just want for a second to ground people in what that actually means, because I'm sure you're hearing a lot about balancing public interest with revenue generation, and I just want to bring it down to the individual level of a player who's playing an EGM, playing a slot machine. Everyone has seen this type of slot machine. This was in my granddad's day. It operated on a mechanical system. It had a cog. If you watched that machine for thousands of plays, you could actually have a sense when this machine was due to pay out because it's set up on a mechanical system that's somewhat predictable and not as erratic as today's machines. My grandfather used to put a coin on a string and keep going until he won, which was illegal, but so was the slot machine. My grandfather is dead, so I feel okay about getting that on the record.

Today's EGMs are quite different. People have seen this one. This is one of the easiest ones to understand. It looks like this old one. It has three symbols. It has one pay line, the line in the middle. It costs 25 cents. This machine actually probably costs 50 cents or 75 cents,

because you play two or three coins per spin. What you can't see about this machine is that this machine is computer-operated and there's this thing called a random number generator. It's a microchip that's inside the computer. If this were a slot machine, the slot machine is on right now. The whole time I'm talking, the slot machine is running. If I press the button now, I get a different outcome, because that number string changes thousands of combinations per minute—thousands—and it happens so fast that you could never, ever, ever predict when it's going to pay off. How many in the room knew that? Sort of?

1720

The Chair (Mr. Kevin Daniel Flynn): I thought the machine had to empty itself every so often.

Ms. Janine Robinson: Yes, that it gets to a certain level and then it's bound to pay out. We call that a pregnant machine; the machine is pregnant.

Mr. Bas Balkissoon: There's legislation for the players.

Mrs. Liz Sandals: There are legislative laws.

Ms. Janine Robinson: There are. The machines do have to pay out a certain percentage of the money that's put in them, and it's highly regulated, that's true. But this machine—you could play this machine for a year and not hit a jackpot or you could play it for five minutes and get two jackpots. That's how random it is. So when you were hearing earlier about conditioning, it's very potent.

Players who play this game today, a lot of them, especially when you think of older adults—those grandmothers I was telling you about—they're thinking that is happening, but it's not; this is happening. In fact, most of the machines are even more complex—and this is still a very simple one. I had to find one that was simple enough for me to explain. This one has 20 lines and it's a one-cent machine. If I were going to tell my teenaged daughter who's 19, and she's going to the casino for the first time, "Play safe. Don't go crazy tonight," and she said to me, "But there's a one-cent machine there," what would I think? One cent, one cent, one cent. This one-cent machine has 20 lines and it might take as many as 20 credits per line. That's 20 times 20 now on a one-cent machine, and similar. I'm going to tell you in a second about a slot machine experience.

If you go online, you can join something called Slot Machines Forum. It's an online friendship group. This is moderated by The Shamus. I'm just going to read this for you. It's called, "Fun Day at the Casino."

"Yesterday, I decided to take the day off work, and make a visit to my local racetrack slots place"—because who doesn't go to the raceway when they take a day off work?—"Mohawk Casino."

"Overall a great day. I convinced my mother to go 50-50 on all of the machines we played"—so he took his mother when he was skipping out on work—"whatever we won or lost, we would split the win (or the loss). It was a good arrangement."

Here come the highlights: "On the 'Panda' game ... we scored 25,000 credits on a two-cent denomination

machine ... for a total of \$500—playing 100 lines”—100 lines at Mohawk.

“On a ‘Quick Hit’ nickel machine ... we scored over 6,000 credits, when we got eight ‘Quick Hit’ symbols ... I don’t even want to think of the jackpot we would have won with a maximum bet.... From a \$10 bill, we got \$342 in ... two minutes.

“On ‘Palace of Riches 2’”—and I’m just going to cut to the chase for you: They won \$182. On other machines, they won at least \$100 with only \$20 on everything they played.

“Overall, we split the proceeds of over \$1,100 after all of our ‘seed money’ is factored out. So ... we both took home \$550, primarily on two-cent slots. For us, it was a profitable four hours of fun!”

Anybody can read that. You can google that. And then everyone else writes the stories: “Congratulations. I had the same thing.” It’s amazing how nobody ever loses. I mean, really, if I could skip off work with my mother, go to the raceway and make \$1,100—that’s more than I’m making in a day, I’ll tell you—that sounds okay. Our culture has really embraced a lot of the myths about the easy win and the gambling. We’ve really glamorized it, and the perspective is getting a little out of touch with the reality of it. This is only one example.

I’m going to get into some of the treatment issues now and some of the things we’re seeing. Some of the emerging issues in the previous discussion about the research covered a lot of this, so I’m not going to belabour it, but Internet gambling and the problem of regulations I think are really something that we’re going to have to consider as a province, and it’s coming at us very quickly. The normalization of gambling—what I just talked about—and the poker on TV, issues with youth—how do I teach my youth to gamble safely if she says, “It’s just a penny machine,” and I don’t know what that means? How do I do that? There are issues with seniors, people who were never exposed to slot machine gambling growing up and don’t know how the machines work. There are issues with aboriginal people and trauma—I’m going to touch on that in a bit—as well as gambling employees. We know that in most sectors, the people who work in the gaming environment are overexposed to winners all day, and they think, “I know something about this.” They will be overrepresented—I didn’t finish that sentence. You know what I mean, though, right? They have a disproportionately high representation of people with gambling problems.

Co-occurring disorders: So the last three research questions that Judith Glynn was teasing out. Something I’m especially concerned with is the mental health and addiction connection when it comes to gambling; the acute need for coordinated services is very real and really pressing. People with gambling problems are surfacing in other systems, for other reasons, or their symptoms are going completely unrecognized. We’ve had clients who have gone to psychiatrists—again, I’m going to use an elderly client as an example—who have said, “Oh, dear, you’re slot machine gambling. It’s a good way for you to

spend a day.” This woman ended up having quite a serious gambling problem. Because she had other depression, or whatever else she was getting treated for, this went completely unnoticed by her primary care provider.

Aboriginal gambling: I was just in Thunder Bay two weeks ago; I do a lot of work in the north with people working with aboriginal clients. Since the residential schools settlement has started to take place, one of the things happening for some people—in fact, quite a few people, and this is anecdotal information that I’m sharing with you—is this. Say I live in a community where there’s a high incidence of problem gambling, I’m struggling with addiction problems myself, my whole community has collective trauma and the residential school settlement hearings are being made—and the worse my trauma, the more money I’m going to get paid; the worse the story of what happened to me is, the higher my cash payout is going to be. People who have very serious histories of trauma are sharing their stories, going public with it and saying it out loud, without any psychological support to do that. What is happening is that it’s retraumatizing them. If you don’t have support and you have a very serious issue like that in your past, if you just put it out there and get no support whatsoever, it could be very retraumatizing. This is happening to people, some of whom have gambling or other addiction problems, and now they have \$15,000. So if I have a gambling problem, you give me \$15,000 and I feel really, really terrible because I have just ripped off the scab that has been protecting me by discussing this trauma in a public setting with you, it seems quite likely that that’s going to end up being possibly problematic for me to handle.

So people have been struggling with some of the settlement money. They’ve been gambling it, they’ve been losing it, and then there have been other consequences in their families based on what just happened with that money. This is a really pressing issue in the north. It’s very serious. I don’t have any great solutions on it, but I just wanted to bring it up, because it’s quite a serious problem.

Treatment options in Ontario: Have you already been briefed on what kind of treatment there is here, outpatient and whatnot?

Interjection.

Ms. Janine Robinson: Okay. The people who get counselling treatment—this is what I’m calling treatment—usually fall into the moderate sphere: they’re the 3.2% of people whom the previous speaker mentioned. Those are the people who come for some sort of formalized treatment. Those people have access to outpatient counselling services: you come to see a counsellor, once a week or whatever. There are residential treatment programs in four locations, and there has been a pretty good response to that. You can get counselling from A to Z in the province—except actually, only to W: From Atikokan to Windsor, there are 50 treatment agencies, and gambling treatment has been rolled into the existing

addiction services that are there. One of my jobs has been to help people with addiction counselling skills get the gambling counselling skills, to be helpful in that area too; so two birds with one stone.

Online self-help and telecounselling: I'm just going to talk for a minute about online gambling and treatment, because this is—oh, there it is. Paul Godfrey, chair of the OLG board, recently stated that online gambling is "something I would explore." If that is something to explore, we need to look at how to minimize the harm associated with such an exploration and how to make sure that there's online access to help and resources that are actually effective.

1730

This is the current continuum of services that exist online in the province. The technology is coming. We have a few obstacles around the freedom-of-information and privacy laws that we're sort of grappling with around how to provide secure treatment online.

There are self-help tools that are anonymous, all the way up to the possibility to do video conferencing with a counsellor. We don't do that yet, but we could do that. We could also be doing email counselling, we could be doing online counselling, and we could be doing group counselling. So far in the province, we're not doing that, but it's something that could be explored.

When we're looking to the future, there's clearly no single solution to the thing that is problem gambling in the province of Ontario. We know that, while it's definitely important to look at using best practices and also acknowledge that the field is quite young, we have a great body of practice—counselling, awareness, different systems—which knows a great deal that hasn't yet been empirically validated about some of the needs in treatment. Rely on evidence-informed practices, yes, but also rely a little bit on practice-informed evidence.

The need for online treatment: It seems that it is abundantly clear, and we have the capacity at the Problem Gambling Institute to do that. It would be particularly effective for populations who aren't emerging for counselling, like poker and sports bettors. It's low-cost, and it's high-impact.

Here's just a snapshot of our website. I gave you a pamphlet about that.

The other issue is other behaviours that are associated with problem gambling, which were also mentioned. We see a lot of clients who have online shopping addiction, online gaming addiction, online pornography addiction, sex addiction etc. There's nobody who is funded, as far as I know, to treat these people. There are all these people who have these problems that are causing a lot of relationship problems, family problems, work problems and so on, and there's nobody who's designated to treat them.

In the problem gambling stream, the counsellors who are already seeing clients with these co-occurring disorders, as Judith Glynn mentioned, would be ideally situated to have their mandate expanded and get some

supplemental skill sets to treat people with Internet addiction.

I'll move on from that. Concurrent disorders: I think that has already been spoken to.

I think the direst need is in the north. Whenever I'm working in the north, the counsellor always says to me, "Yes, but I'm it. I'm the one. That's me. I'm the person." They're not necessarily people who are fully qualified to work with issues of trauma and concurrent disorders. But it does seem to me that bundling those services—if the research is still teasing out which caused which, we can still be treating them simultaneously.

Another successful model that has been happening is the use of webinars. Do you know this expression? It's web-based training, Internet-based training. You sit at your computer and listen to me on the phone, and I blather away like I am now and show a PowerPoint presentation or do something online. We've done this with bankruptcy trustees at our institute. We've done it with family doctors, and we have the capacity to do that on a widespread basis. We know most people who have gambling problems go to their family doctor, and it's missed, right? The gambling piece is missed. We could help develop that skill set. We also train gambling counsellors online.

I don't want to suggest that online is ever going to replace face-to-face training for counsellors, just to put that out there. It is a human service; we do need that human element in it when we're working.

Another really successful model is the multilingual program gambling service. You have the brochure about that; it's the multicoloured striped one. This has allowed us, in the province, to offer gambling counselling in 17 languages for less than \$70,000 a year. What we do is we have trained people who are working at family counselling in the Spanish language to provide treatment for problem gambling, and then we pay them on a fee-for-service. They see a client—we pay them \$66 for the hour to see the client; we pay them to do that—and they treat the client in their language.

We have reached so many people this way. It's cost-effective and it's got reciprocal benefit—the clients benefit, the non-mainstream agencies benefit and the mainstream agencies benefit because we're reaching those people who we weren't reaching before and we're also building our cultural capacity at our agencies. It's been a very, very successful model. I think it could be expanded to other regions.

I'm going to end here in a second, but I just wanted to mention working where the people with gambling problems are. The work that we've been doing with Ontario Lottery and Gaming to help them identify and respond to problem gambling red flags in the casinos has been a very good way to do early prevention with players, but also to do later stage referrals for people who already have gambling problems. They can get the brochure to come and call us.

That's it for me. I would be very happy to have any follow-up discussions with you and I'm more than happy to take any questions.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much. We asked you to come because, obviously, we didn't hear a lot about it during the proceedings. I guess we anticipated that we would and we didn't, and through Ms. Sandals, we were able to arrange this visit today.

Just to start the discussion off, is there a reason we didn't hear from you or from somebody else talking about the same subject? We just didn't hear all that much about it.

Ms. Judith Glynn: I'm surprised that you didn't. I wonder if there was a lack of awareness, but we do know, for example, that problem gamblers don't show up for treatment. The percentage of people who have a moderate to severe problem who actually present for treatment is extremely low. Now, I know it's low for many mental health disorders, but I think for problem gambling, it's perhaps on the extreme end of that.

What we think is going on there is that some of the same barriers to treatment are probably the same barriers to even acknowledging that it's an issue. That might account for the fact that you didn't hear personal testimony from problem gamblers.

The fact that you didn't hear from service providers surprises me, and I wonder if it's whether—because the problem gambling service providers are fairly well-funded, and that system is fairly stable, then—I mean, there are needs there, there are areas into which they can expand, but if you had a treatment centre that was providing service for all forms of addiction, they may have emphasized the other forms of addiction because that's where the funding pressures existed.

I wonder, do you think that problem's somewhat true?

Ms. Janine Robinson: It doesn't resonate falsely, but I'm a little baffled, especially that online gambling hasn't been a strong feature for people. Yes, I'm surprised. People just get mired in what they've been working in for years and years, and some of the newer issues they haven't really fully contemplated. I don't know; I can't quite understand it.

The Chair (Mr. Kevin Daniel Flynn): I mean, I've had friends who claim they always win when they go to the casino. I know that's obviously not true. There's a stigma attached to it. Obviously, when you do talk about it, you don't talk about the \$5,000 you lost last night; you talk about the \$20 you won. Does it always just come crashing down at the end with "The house is lost," or do people sort of realize at some point along the way that "I'm on the road to that"?

Ms. Janine Robinson: Most people alter their problematic behaviours on their own right now, largely due to financial pressures. When they come to counselling, unfortunately, they're at the very end stage of problems, and overwhelmingly they're divorced or bankrupt. So the people who do end up coming to our services across the province have very severe consequences. The ones who are less severe, or even who are bankrupt, might just resolve the gambling in another way.

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Ms. Judith Glynn: Just to add to that, there is a very high rate of self-recovery and it will reflect in year-over-year assessments of the prevalence of problem gambling. What the emerging results from a study that has been following 4,000 people in the Belleville area will show is that there is a fairly high percentage of people who move in and out of problem gambling status. Approximately 50% of the annual turnover is people re-entering problem gambling status, who seemed to self-recover, and did for a period of time, probably because of those financial pressures. But then the problems re-emerge within, I think, a two-year cycle.

The Chair (Mr. Kevin Daniel Flynn): Let's hear from Jeff and then Liz.

Mr. Jeff Leal: It was interesting—you talked about how Norway has a fairly sophisticated tracking system for people who are problem gamblers. We often hear, through the various media outlets here in Ontario, about the Ontario lottery corporation talking about responsible gaming, and the proceeds from gaming in Ontario—a certain amount—are put back into programs.

What is preventing us—or should we be looking at the Norway example that you provided? I don't know how much training is given to people. In my riding of Peterborough we have Kawartha Downs, which is a harness race operation, plus a slot operation. How much training—or should we provide additional training for those individuals to be on the lookout to better identify people who are potential problem gamblers?

Ms. Judith Glynn: I think one of the major obstacles is that in all of those jurisdictions you must present ID when you go into the facility, so they know who you are. That's not the case in Ontario. There has been a lot of resistance to that. I'm not entirely sure where the resistance comes from because the attraction of remaining anonymous might only exist for people you might not want in the facilities anyway. I think what you have are cultures in those countries where the requirement to present ID is not thought of as a strange request. I think that's probably the very first barrier.

The other thing that they do in those countries is that in some cases they don't allow people who are full-time students, in school, or recipients of social welfare to gamble. They're simply not permitted to enter gambling facilities. I think what you'd find is that some of those measures would be considered intrusive in our culture. But the presentation of ID is really the foundation to being able to do all of this tracking and detection. I think you've got resistance at that front end for the presentation of ID. If a person inserts their player card, then the operator will know who they are while they're in there gambling.

But I think the other place where you're going to get resistance is in that requirement. Whose job is it to first detect and identify the possibility of problems, and then to intervene? I think what you'll get is a lot of nervousness around assuming that responsibility here in Ontario. If we were going to move in that direction, there

would have to be really strong legal analysis and provisions. You'd need some technology to support the identification of people coming in and you'd need the technology to do the tracking, and then you would need—I think the staff could easily be trained to intervene. That would be something that Janine could speak to. But the resistance is going to be in identifying people as they come to the venues, and then once you have signs, based on their play behaviour, that they probably have a gambling problem—there is quite a bit of research to tell you what those signs are—you have to have an environment where the operator is responsible legally for detecting and intervening, and we do not have that in Ontario.

Mr. Jeff Leal: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Liz?

Mrs. Liz Sandals: A couple of questions. I found the research that you had around bio-psychosocial factors and how gambling addiction is interrelated to other addictions and to mental health issues really fascinating.

Do we have any information about, if you treat problem gambling, what happens to all those other concurrent disorders or, conversely, if you treat the other concurrent disorders, what happens to the problem gambling? Do we have any information on how treatment one way affects the other concurrent disorders?

Ms. Janine Robinson: Can I speak to the clinical experience first, and then you can speak to the stats about it.

Clinically we know—let's take depression, for example. We will assume a client who comes in our door for gambling counselling is experiencing depression. In 80% of the people who are experiencing depression, the depression will clear up when we control their gambling. The other 20% won't. So then we know the depression was either—

Mrs. Liz Sandals: The depression is the primary—

Ms. Janine Robinson: It pre-existed, right, or it's endogenous depression and needs to be treated additionally. We also know treating people with certain antidepressants has a spin-off effect. There are certain drugs that will regulate the impulse systems that are effective. So we know some of that.

Most of our counselling services in the province don't prescribe medication. Most of our counselling services are talk services. One of the needs that we have there is really to have more consultation services with psychiatrists because we do need to be able to figure that out for clients. If they present for gambling and they need to be treated for terrible debilitating anxiety, we can do that, and we should be able to do that in the same place.

Ms. Judith Glynn: In terms of the research, there is some research that looks at how you treat those multiple co-morbid disorders, but it's minimal. Definitely, if I was talking to the research field and telling them a place where they perhaps have failed to provide the information that policy-makers and health system designers need, it is that health systems piece. So which disorder do you emphasize in terms of treatment? How do you integrate

the treatment? Is there a certain order that should take place? In that case, Janine's point about evidence-based practice, if there's evidence that's there, the research really doesn't exist, so we might have to come at it in the other direction.

The other thing that I think Janine will confirm is that when you look at the different pathways to problem gambling that have been modelled, there is some sense that of those who do present for treatment, a large percentage are the ones with the most complex set of co-occurring challenges. So there is some need to address that in the treatment system, and Janine referred to that. There is some need for the treatment system to have the capacity for coordination and perhaps working with researchers and seeing what works best in terms of integrating the treatment of multiple presenting conditions.

Mrs. Liz Sandals: So you've got some capacity to switch back and forth between the medical and the counselling?

Ms. Judith Glynn: Yes.

Ms. Janine Robinson: They complement each other.

Ms. Judith Glynn: Yes. I think they need to complement each other, and counsellors need to have access to MDs and psychiatrists in a case consultation sort of approach.

Mrs. Liz Sandals: Okay. Then, the other thing that I found interesting was that—well, all sorts of things were interesting, but what twiggged my curiosity was a lack of understanding about how an electronic gaming machine really works, i.e., it's a random number generator and the odds are set, and the fact that you've gone for hours and didn't win doesn't mean you're going to win next. Is that something that's a prevention opportunity and have we looked at ways of educating more people so that they actually understand probability?

Ms. Janine Robinson: That has been happening. The Responsible Gambling Council in the province is responsible for that type of messaging. They've certainly been doing some work.

In the casino training that we're developing, that we've been doing, the number one role of staff is to help create an informed customer, to help players understand how the games truly work and what the true odds of winning a certain game are. The drawback of that is it doesn't happen automatically. It only happens if the player is complaining or demonstrating some sort of problematic behaviour. So if somebody's just quietly playing for four hours, they'll never get that information, but if they say to the person, "Jeez, I just spent \$400 and I haven't won anything," then we're training them to say, well, this is how the machines work and how to convey that information pretty clearly. There's no way people get that information until they're demonstrating a problem—

Mrs. Liz Sandals: But you're finding that people who are addicted to slots genuinely don't understand how slots work?

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Ms. Janine Robinson: Absolutely. They don't. They'll tell us—when I'm working with them in a

session they'll tell me there's a random number generator. Yet still, when they go to the bathroom at the casino, they'll put their chair up on the thing so no one can steal their jackpot, which demonstrates they really don't believe—

Mrs. Liz Sandals: They don't understand.

Ms. Janine Robinson: It hasn't gone in, because I can go like this and press the button, or I can scratch my nose and press the button—I'm going to have a completely different outcome. So people really, truly don't know how the games work.

There's a lot of public messaging that could be done about the game itself. These games have no brakes. They have a gas pedal without a brake.

Mrs. Liz Sandals: Thank you.

Ms. Judith Glynn: Sorry, I was going to just add to that. In terms of research about the success of education around how gambling works, it's mixed. There was a large study in Alberta where they educated university students about randomness, and they did a really—it was a strong research design. Over a period of time, they showed a dramatic increase in the understanding of how randomness worked in different forms of gambling, and yet, it had a very minor impact on gambling behaviour.

Then there was some research by Ladouceur in Quebec which showed that you could correct the cognition. People would report an improved understanding of gambling, but once they got into the venue something sort of took hold, and I think Janine will have heard this as well.

But that doesn't mean that we shouldn't make those attempts to educate. The research evidence is mixed, but you do have to ask yourself, as responsible providers of gambling—and we know that this is a difficult concept for all of us to understand; there is still a compelling case for doing the education you're talking about, for doing a really good job of trying to dispel those myths.

OLG has had some campaigns in the last couple of years that have tackled some of those myths. I think there is a very compelling case for trying to correct those errors, but in terms of treating problem gamblers, there is resistance and those are difficult cognitions to correct.

Mrs. Liz Sandals: Yes. What's really interesting is the study with the university students who, presumably, were a range of people who reflected the general population, and it didn't change their gambling behaviour.

Ms. Judith Glynn: They were quite surprised by the result.

Mrs. Liz Sandals: Okay.

The Chair (Mr. Kevin Daniel Flynn): Any other questions? Thank you very much for coming. I remember a line from a movie that said people weren't addicted to winning, they were addicted to losing. Is there any truth to that, or is that just Hollywood?

Ms. Janine Robinson: I've heard that line too. That's one of the first sort of psychological understandings about it. People with gambling problems had a failure—do you know what it's called? The drive to punish

yourself; they had that. It hasn't been scientifically supported.

Ms. Judith Glynn: Except to some extent, I think what they might be talking about—that's the Matthew McConaughey-Al Pacino movie, the name of which I've forgotten, a great gambling movie about sports betting.

The Chair (Mr. Kevin Daniel Flynn): That's right, yes.

Ms. Judith Glynn: I do think that if you look at that whole idea of the reward schedule—the high-frequency, variable reward—gamblers do report that the activity of gambling, the excitement in those moments before they know the outcome, is part of the reward. So winning is not the only reward; that's not the only thing that's going on.

In that sense, whether there's that intransigent group that really does want to lose, or whether just gambling, generally—certain forms of it—offers that thrill all the time, and then the chance that there will be the bigger thrill of a win; but the chance outcome itself seems to provide them with something that they want.

Ms. Janine Robinson: Absolutely.

The Chair (Mr. Kevin Daniel Flynn): Jeff?

Mr. Jeff Leal: Just an anecdotal story. You talk about new Canadians—Chinese—I always remember when I was in residence in university, on Sunday night, Chinese students would get together for a game called mah-jong, which, as I understood it—and they were right next door to my room in the residence—was a game like dominos of some description. But big money was exchanged during the game of mah-jong. It was always very fascinating to me to watch them. They were very intense as they were playing—

Ms. Janine Robinson: It's a very important cultural game, mah-jong.

Mr. Jeff Leal: It is, yes; I've heard.

Ms. Janine Robinson: Yes: it's weddings and all kinds of very important times. It's very lively. People will say, "I was at my grandma's knee—that's when I learned it."

Mr. Jeff Leal: Certainly, it was interesting to watch. but the dollar value that was on the table in playing this game—I mean, for students, you know, you're living on Kraft dinner and a lot of other things. It was fascinating.

Ms. Judith Glynn: It must have been strange to watch that kind of money disappear. I was going to say, related to that, in North American countries and much of Europe, lower socio-economic status is strongly correlated to problem gambling status. In some Asian countries, the reverse is true because it is a status—

Mr. Jeff Leal: Upper income—

Ms. Judith Glynn: Yes. You have higher rates of problem gambling in—

Mr. Jeff Leal: Very much so.

Ms. Judith Glynn: Yes, and that's why, and you've—

Mr. Jeff Leal: Hong Kong is a classic example of upper income—

Ms. Judith Glynn: Yes, because it's status to gamble, and to gamble large amounts.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today.

Ms. Judith Glynn: Thank you. Thanks, everyone.

The Chair (Mr. Kevin Daniel Flynn): We really appreciate it. That was a great presentation. Thank you.

Ms. Judith Glynn: If there is any material you would like forwarded or condensed or anything, let us know.

The Chair (Mr. Kevin Daniel Flynn): Perfect. Thank you.

For the members of the committee, you've been given three reports today, I think, or three pieces of information from the Legislative Assembly. One is the final report deliberations and the recommendations from the interim report. If we could bring them to the next meeting—I know we've been swamped with paper, but this is one we need to have at the next meeting.

Interjections.

The Chair (Mr. Kevin Daniel Flynn): We're just having a discussion about all the summaries we've received to date, and now we're starting to get into the final report and saying whether it's reasonable to expect the members would still have the summaries that were provided by staff. I know, if we kept all the paper each had, we'd fill this room. Do you have copies of the summaries? You do?

Interjections.

The Chair (Mr. Kevin Daniel Flynn): Because if we don't, we may as well admit it, and ask you to bring them.

Mrs. Liz Sandals: I have a binder with some summaries—but I wouldn't guarantee they're all there, and the other thing is, it's getting quite weighty to carry around—

The Chair (Mr. Kevin Daniel Flynn): Yes. Well that's just it.

Ms. Carrie Hull: What about if we have binders that we keep here—

Interjections.

The Chair (Mr. Kevin Daniel Flynn): That's a good idea.

Interjections.

The Chair (Mr. Kevin Daniel Flynn): Bring what you have.

Is that it?

Interjection.

The Chair (Mr. Kevin Daniel Flynn): Oh, right. The interim report will be ready Monday, and the intent is to table it before our meeting on Wednesday. Just so we know everything went smoothly with the printing and the translation.

Thank you very much. We're adjourned.

The committee adjourned at 1756.

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MENTAL HEALTH AND ADDICTIONSCOMITÉ SPÉCIAL DE LA SANTÉ
MENTALE ET DES DÉPENDANCES

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*The committee met at 1541 in room 151.*MENTAL HEALTH
AND ADDICTIONS STRATEGY
STRATÉGIE SUR LA SANTÉ MENTALE
ET LES DÉPENDANCES

The Vice-Chair (Mrs. Christine Elliott): Good afternoon, everyone, and welcome to our session of the Select Committee on Mental Health and Addictions. We have three presenters on the schedule for today, and I know we want to be able to hear fully from all of them.

DR. RICHARD O'REILLY

The Vice-Chair (Mrs. Christine Elliott): Our first presenter today is Dr. Richard O'Reilly. I'd invite you, Dr. O'Reilly, to please come forward. We're very pleased that you were able to join us today, and we look forward to your presentation. We understand that we will have the opportunity for some questions as well. Welcome.

Dr. Richard O'Reilly: Thanks very much, Madam Chair.

The Vice-Chair (Mrs. Christine Elliott): Please, feel free—there's water there. Please make yourself comfortable and start whenever you're ready.

Dr. Richard O'Reilly: I appreciate the opportunity to come and address the committee. I really am very pleased with the committee's hard work. I've read the interim report, and this is clearly a key issue for many of our most vulnerable citizens.

I do want to just tell you briefly who I am and who I'm not. I'm a professor at the University of Western Ontario and I've spent my life, pretty well, working with people with severe and persistent mental illness. I'm the past president of the Ontario Psychiatric Association, but I'm not the president, and I'm very definitely not giving the view of psychiatry here. I think the committee's already heard from Dr. Paul Mulzer.

The committee has my written report. I'm just going to highlight some of the key issues from that report. I think one of the things that struck me in reading the interim report is that the committee has heard some conflicting testimony and ideas from individuals, and there are some areas of fairly sharp controversy around involuntary treatment and liberty issues. But I think the

major issue that may cause confusion is that when we talk about treatment of people with mental illness we often hear, and in the report it's cited, that one in five people have mental illness in Ontario. That is true, but it takes away, I believe, from the fact that a very small number of people have severe mental illness, which really robs them of the ability to work and live normal, productive lives, and often robs them of the ability to make treatment decisions for themselves. That is the group of individuals that I really want to talk to the committee about.

My presentation is going to be about people with serious mental illness. These are individuals primarily with schizophrenia and bipolar disorder, and some other psychotic disorders, and a very small number of people with very severe personality disorder. These individuals make up approximately 2% to 4% of our population.

Why should we care about them? Well, we are a caring society, but I think, very importantly, these are our most impaired individuals, and it's my view that, as they are our most impaired individuals, they should get priority when it comes to treatment. In every area of medicine, people with the most severe illness get priority, and I think this often doesn't happen for this group of individuals.

There is also a price for not providing the treatments. If we don't treat, supervise and provide care for these individuals, it merely shifts the costs on to other areas, such as the criminal justice system, police, courts etc.

I have proposed four items for the committee's consideration. They're a little bit disparate; that's "disparate," not "desperate." One is the principle that we need long-term commitment for this group of individuals; the advantage of a community of caregivers when providing care for the individuals; need for amendments to our mental health legislation; and finally, but certainly not least, a recommendation that Ontario seriously consider the establishment of a treatment advocate or ombudsman.

First let me talk about the long-term commitment. We often talk about the seriously mentally ill, but in other contexts, they are called serious and persistent mental illnesses. These are individuals with lifelong illnesses. Schizophrenia we can control with medication but it's not like an infection where the illness disappears with treatment. It's more like arthritis or asthma. Unfortunately, one of the symptoms of schizophrenia in a significant minority is lack of the understanding and appreciation

that a person has an illness and needs the treatment. So frequently, individuals stop treatment when they're treated and released from hospital.

It was essentially this failure to understand people with serious mental illness that led to the problems after deinstitutionalization started in the 1960s. At that time and shortly afterwards, we find that individuals were treated well in hospital, released, stopped their treatment and were readmitted. Many patients, unfortunately, do not get readmitted because they die from suicide or from lack of judgment—sleeping outside on a minus-20 night.

I should say that deinstitutionalization is not an historic event; it's an ongoing process, and now we're at a stage where we're treating people with the most serious illnesses in our community. Failure to live up to our commitments with these individuals, I think as the committee knows, results in individuals who are homeless, incarcerated or just abandoned in flophouses and shelters.

There are too few psychiatric beds in the system. I'm sure the committee doesn't want to hear me say that; I'm sure the government doesn't want to hear me say that, but unfortunately, wishful thinking doesn't take away the reality. There is an opportunity to work and manage, I believe, with the amount of beds we have, providing we have the correct services in the community.

Here's where I differ from some of the presenters you've had in the past. I see frequent reference in the interim report to the need for a home, a friend and a job. I firmly believe that these are critical things for many individuals in the broad group of one in five who have mental illness. But for people with serious mental illness, although a home, a job and a friend are all important things, treatment is the absolute foundation of recovery. Without treatment, a home, a friend and a job will make no difference.

My experience and the experience of my colleagues is that we frequently place an individual in an apartment only to have that individual stop their treatment, become psychotic, start hallucinating, start shouting out at night and be evicted. Similarly, we will not be able to maintain a person on a worksite if they develop paranoia about their workmates and start acting in that way.

So for people with serious mental illness, we must ensure treatment and we must have a system that facilitates the supervision and assistance with that treatment pretty much through many of these individuals' lifetimes. Not every individual with schizophrenia is affected in this way of losing insight, but many are. Reports and research suggest that that number is about a quarter, so that would be about a quarter of a per cent of the citizens of this province.

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What can this committee do to ensure commitment to long-term care and treatment? Firstly, I think, understand the nature of severe and persistent mental illness and identify this group as a priority for service. Certainly, I would encourage you not to, in any way, write off this group of individuals. They can be severely affected, and I've heard some people say—unfortunately, some col-

leagues say—that we should treat people who are less severely ill, that that's where we'll get the best "bang for our buck." Certainly, if we do that, this will not prevent individuals' developing severe and persistent mental illness. There's no way to prevent it. The only thing we can do—and I think we are actually doing reasonably well in Ontario—is the early intervention in psychosis, because we know that early intervention improves the long-term outcome of these disorders.

A very important thing that I would ask the committee to consider is the issue of money. Basically, my advice is, follow the money. It is critical to hold the LHINs and hospitals accountable for ensuring that money that's designated to go to the treatment of severe and persistent mental illness does that. Why am I so insistent on this? Because we have a long history of the money being diverted to other services, to services for individuals with less severe mental illness and services for people with other medical disorders. I believe it is just not good enough that government walks away from this responsibility. I think that the hospitals and the LHINs must be held to account.

My second principle, if you like, is to encourage continuity of caregiver. Many people on this committee will have already heard, and heard many times, about continuity of care. Continuity of care and continuity of caregiver are different things. In fact, continuity of care implies that there's a change in caregiver. In many of our hospitals and most of our academic health sciences centres, individuals who are admitted to a psychiatric unit are discharged to a different service. Now, I've worked in Saskatchewan, and I know that many other hospitals, community hospitals in Ontario, do not run that system. The psychiatrist who sees the person in the community looks after the patients when they're admitted and continues to look after the patients when they're discharged.

In addition to saving all sorts of time in assessing individuals, this system keeps the hospital honest, basically. A psychiatrist will not admit people to hospital unless it's really necessary, because she or he knows that they'll be seeing the patient the next day. Perhaps even more importantly, a psychiatrist will not discharge the person before they're ready to be discharged and there's a reasonable plan, because he or she will be faced with the mayhem that we know results from that in the community.

Why do we not do that? Well, there are some problems when there are many, many psychiatrists admitting to the one unit. But I think it's just something that's been glossed over. There's very little research on it. That's one thing that I would encourage, and I think that a request for proposal could be crafted to do that. Certainly, I think if the committee members think about what I'm saying and the position of a hospital discharging someone, they will see the advantages in that approach.

I'm going to move on quickly to legislative change. When I drafted my written proposals, I put in a number of things which I felt were important because they affected a large number of people in the community. The

committee may decide to question me about those recommendations. I'm actually not going to address them today, and the reason I'm not going to address them is that since I wrote the written submission, there has been a bill, Bill 16, which has come before the House to amend both the Mental Health Act and the Health Care Consent Act. It addresses some fairly sensible things. One is one of the amendments that I'd actually recommended; it's a change to what happens to a community treatment order after a physician issues a form 47. It's basically saying that that should not void the community treatment order.

However, I've been, for many years, pushing a small amendment that would make a huge difference to a small number of people in Ontario. I've written it out for the committee members. Basically, it would change the way that the Health Care Consent Act works to allow treatment to start for a person who is incapable of consenting to their own treatment. Once the independent Consent and Capacity Board has adjudicated their case and found them incapable, currently, the case has to go through the courts. Regrettably, the glacial pace of our courts in resolving these issues, which may go and have gone the whole way to the Supreme Court, is incompatible with clinical realities. Many individuals have been kept in our hospitals for years upon years without treatment. This has to stop.

I would really encourage the committee or someone from the committee to contact me after my presentation and maybe quiz me a little bit more about this. I'm not going to take a lot of time, but what I really want to see is something go to the minister to ask her to add this to the amendments in Bill 16, because this would appear to me to be the opportunity. I've been told many times, "We're not amending the legislation. We're not going to consider that." It just does appear that this is an opportunity for a non-controversial amendment to the act.

My final proposal is that Ontario develop a position of a treatment advocate—or perhaps ombudsman or ombudsperson would be a better description of the role that I foresee. I think that the committee members are well aware of how an ombudsman or overseer can challenge and bring about changes in systems that have problems.

In mental health, how I would see an ombudsperson act is, for example, looking at a situation where an individual is being denied admission to a hospital, perhaps even not being admitted on a certificate, or is being discharged after 72 hours without any real change, the ombudsman could follow up with the hospital and the clinicians involved and question why that has happened.

I have suggested in my written submission that that ombudsman be a psychiatrist. I believe that in that way, this could be done on a collegial basis in most situations, but of course, being a physician gives the position a lot more clout when dealing with individual clinicians and with hospitals.

I would point out that the deck really is surprisingly stacked against treatment, particularly treatment where individuals are refusing and do not understand the need for treatment. If a person has a serious mental illness and

refuses treatment, actually, the path of least resistance for a physician is to leave that person alone. If the physician decides to take on the case, then they can expect to spend a lot of time before the Consent and Capacity Board, a lot of time talking to relatives and substitute decision-makers, and they're going to be dealing with an individual who maybe has quite a difficult problem with paranoia, uncooperativeness. It's much easier to deal with individuals who've got less severe illness and are more willing to take treatment, but that's not what our system should just be about. We have to ensure that these individuals receive fair treatment.

I could go on. I think probably at this stage, I will end my oral submission. I have outlined the position of treatment advocate more fully in the written submission. I really do hope that the committee will seriously consider that position.

Before I end, I'll just say that I know that the interim report mentioned a system navigator or system navigators, and I think that's a great idea. But when the system is actually pushing back, I think you need more than just a navigator; you need an advocate. Thanks very much.

The Vice-Chair (Mrs. Christine Elliott): Thank you very much, Dr. O'Reilly. I know that the members of the committee do have questions. Perhaps we could start with Sylvia Jones, please.

Ms. Sylvia Jones: You've covered a whole bunch of issues that I'd like to question further, but I'll start with this: you mentioned the challenges of discharging individuals to a different service provider and the challenges that that involves. I must admit, when I came into this committee, I expected to hear about the lack of service providers. In fact, we've heard that there are many, many organizations providing different levels and types of services for mental patients.

Can you explain further what the challenges are from discharging patients out of a hospital and where you see the problems are there?

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Dr. Richard O'Reilly: Well, one of the problems I think is included in your question, that we do have many, many services. We've got a patchwork of services. I think that that's actually one of the problems. There are too many different services, and it becomes confusing, both to the patients and their families and also to the health care providers. Different services have different rules about whether they'll take on individuals or not. Different services will be more assertive in following up individuals who don't present for service and for treatment. But the real issue, I think, is one of commitment. A physician and a team in the hospital have somebody who has got a history of non-compliance with their treatments in the community, a person who lacks the capacity to appreciate the need for treatment, so there's a very high likelihood that they will fall out of treatment. It's very easy to make a referral to an agency, but a lot of times when my colleagues are doing that, it's tongue-in-cheek, and they know the person will not follow up or will shortly drop out.

A much more difficult thing to ask my colleagues to do is to actually commit themselves to providing the treatment for that person in the long term. That's again what I'm saying: the long-term commitments. When a colleague is asked to do that, they will consider things that they wouldn't consider when they're discharging to another service. They will consider what to do when the person predictably doesn't follow up with treatments. They will consider the possibility of writing a community treatment order. They consider the sense of meeting with family to develop a crisis plan for the individual: things that all too often, as I think the committee knows, do not happen.

Ms. Sylvia Jones: Thank you.

The Vice-Chair (Mrs. Christine Elliott): Moving next to France Gélinas.

M^{me} France Gélinas: I thought your presentation was fantastic. I thank you very much for coming.

You called it a small amendment with huge changes to a small number of people. I was surprised to hear you say "non-controversial." Any change to Bill 16 seems to come with an awful lot of work. What makes you think that it could be feasible, and how do we get it done?

Dr. Richard O'Reilly: Well, the reason that I say it's non-controversial is that I've spent the last 10 years researching the ramifications of such a change. Let me just briefly tell you that in my hospital, we had almost two patients a year who appealed findings of treatment incapacity from the consent and capacity boards, who independently made it to the courts. The average delay in initiating treatment for those individuals was 253 days, almost nine months—the longest was two years—at an incredible cost. Maybe southwestern Ontario is different, and there's something in the water. I looked at the whole of Ontario and what the consequences would be of making the change that I suggested. What I found was that only six individuals in a period of 15 years—there were only six cases where the courts overturned the finding of the consent and capacity board on treatment capacity. The remarkable thing was that from public records, I was able to trace the life histories of those individuals: Four ended up getting treatment. Typically, after six to eight years, they were detained involuntarily, so they lost their liberty for six to eight years in hospital. One individual is still in hospital, 25 years later. He's not being treated; he has been held untreated, with a treatable disorder by all accounts, for 25 years in this province.

One patient, actually, probably did quite well from our current system. She was discharged before the court hearing, but then she took the treatment voluntarily.

Really, I think that whatever about the cost—and there's a huge cost to the system—the actual liberty interests of our citizens are being impaired by the current Health Care Consent Act and the provision.

M^{me} France Gélinas: The model that you talk about, making your treatment decision based on being the caregiver for the long term, is this a model that exists anywhere?

Dr. Richard O'Reilly: It does. Even in some parts of Ontario, many community hospitals actually run such a model. So the psychiatrist goes to the hospital in the morning, does his or her rounds and then runs an office-based practice outside the hospital in the afternoon and will follow up. If they admit someone from the emergency room, that's their patient. They will continue to follow that patient. So they are very much committed to the patient. I would envision a situation where we would actually have some outpatient departments and non-bedded services run by our hospitals.

One of the other things—I'm going to say to the committee, I'm not sure if you've heard something like this before, but we talk about institutional versus community services and we lump all the hospitals into the institutional sector. But for heaven's sake, general hospitals are a community-based service that's actually helped to maintain somebody in the community. Many of them are actually called community hospitals. I think there's been some illogical thinking around this and I would favour general hospitals actually running the services that would provide care and treatment for individuals who are discharged from their in-patient wards.

M^{me} France Gélinas: How about the rest of the team that would support? I understand the psychiatrist certainly has an important role to play in the care. There would also be other people? Do you see those as being employees, as in outpatient hospitals, who would also follow the patient?

Dr. Richard O'Reilly: Absolutely. If the hospital actually runs an ambulatory care service, then the social worker and maybe case-manager nurse from the ward can continue to be involved in the patient's care in the community. That's one of the reasons I would go to that rather than our current office-based practice, in which the psychiatrist has a private office.

The Vice-Chair (Mrs. Christine Elliott): Thank you. Who would like to—Ms. Jaczek.

Ms. Helena Jaczek: Perhaps going back to some of what we heard, we heard over and over from parents, from families, that they had a teenaged son, relative or sibling; they knew something was wrong. They went to the family doctor. The family doctor had a tendency to offer some bromides, essentially. There didn't seem to be the recognition that this was something serious. The family offered, "Something isn't quite right"; the family doctor was more reassuring.

You did say that early intervention is being done well. My question is, do you think there really is a problem on the part of some family physicians actually recognizing when they're dealing with a serious mental illness? Because obviously, then, the early intervention does not occur. Is there something that needs to be done to ensure that that sort of screening that is occurring out in the community at that first psychotic break is there to help physicians with that sort of diagnosis and to be able to at least get into the early intervention?

And if I may, just to continue that thought, families, once the hallucinations were so florid or whatever symp-

tom occurred that they got their child relative to the hospital, then they were excluded from treatment decisions and potential side effects. The young person was then dumped back on them—in their view, prematurely—and they had not been properly communicated with, yet they've had the responsibility in terms of follow-up. That's a scenario that we heard over and over. Perhaps you could just lead us through that.

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Dr. Richard O'Reilly: I work a lot with families, and I hear the same stories. I'm very familiar with these stories.

With regard to the first question of an individual presenting with symptoms that may be schizophrenia, that is actually difficult. It can be very hard to decide whether somebody has a psychosis. We're not even too worried about whether it's schizophrenia or bipolar disorder, but it's a psychotic disorder. Many of our young people smoke cannabis and use other drugs which can mimic some of the symptoms of mental illness. Moreover, the early signs, before there are actually psychotic symptoms, of withdrawal, non-communication etc., are actually part of teenage, adolescent life, so it's difficult. I don't have a great answer for that. I think the more education we can provide family doctors the better. Maybe other individuals have a more comprehensive approach.

However, when it comes to a situation where an individual clearly has a psychotic illness, is so diagnosed, has been treated and is returning to the family, this is a perennial problem where the families complain that the system and the doctors and other professionals don't give them information.

I'm going to say a few things to the committee, and you may have some supplementary questions. Within our Health Care Consent Act, actually, we have a perfectly good provision to assess someone as incapable of consenting to the release of their records: a test, based on case law, that the individual doesn't understand that they're releasing their records, that that's what they are being asked to do, or doesn't appreciate the consequences of releasing or withholding their records. The problem is this is almost never used, and I think it's almost never considered by mental health professionals. It would be applicable in many of these cases.

If a young person is returning to their family, and the family is going to be responsible financially for them, perhaps, for their medication and for monitoring their treatment and symptoms, then surely the family does need to know what those early signs are of relapse, what the medication is, what the side effects are.

I think, in many cases, if professionals had that discussion directly with the young person, they could actually bring the person around to see that, yes, it is necessary. In many other cases, I believe that individuals may be refusing to have their family in the information loop because of delusions or other problems which are really a reflection of that lack of capacity. The Health Care Consent Act provisions could be used in that case. There are things that can be done.

Unfortunately, sometimes professionals say, "Oh, there's nothing we can do about it." I tell my psychiatric trainees and medical students never to say that, because it's almost always wrong. There nearly always is something that can be done.

The Vice-Chair (Mrs. Christine Elliott): Mr. Leal?

Mr. Jeff Leal: Thank you, Dr. O'Reilly, for your presentation. You talked about the possible role of an ombudsman in this area. If we had effective case management for people with mental illness to come up with a plan, would you still need an ombudsman to look at things?

Dr. Richard O'Reilly: I think we still would.

Mr. Jeff Leal: Why?

Dr. Richard O'Reilly: For one thing, would the individuals who need case management get a case manager? We do have very effective case managers, but unfortunately, I still think that they have difficulty making sure that an individual is admitted. Sometimes the case manager comes with somebody with a psychotic illness to the emergency room and tries to give information to the clinical staff, who typically will say that they may be very busy. They may take the information but the person may still not be admitted because of lack of services. I think that the case managers do not have the authority to take the next step.

Mr. Jeff Leal: What would happen if this committee, through our deliberations, decided to redefine the role of case managers in the province of Ontario?

Dr. Richard O'Reilly: I hate answering a question with a question, but what would the redefinition be? If the committee could somehow empower case managers so that they could somehow insist on service being given, that could make a change, but I'm not sure how that could come about.

Mr. Jeff Leal: I didn't mean to pose the question back to you. I guess what I'm getting at is that we've had a lot of deputations over the last number of months that have made very positive suggestions on how the role of a case manager could be changed in terms of their role or responsibility, what they might be looking at in terms of dealing with an individual with mental illness.

Dr. Richard O'Reilly: My vision of the role of ombudsman/advocate is that such a person would try to resolve the problem at ground level with the clinician, and even ask, "Why did you not admit someone?" Throwing light on practice is a very good thing. When I know I'm being monitored, I think about things very carefully. I think that would be good.

My vision is that if there was not a satisfactory response or if the problems were repeated, that the ombudsman could go to the next level, the chief of staff in the hospital, the CEO, the minister, so that we could actually find some remedy for the problem.

Certainly, we've been hearing for 20-years-plus about these problems of people falling through the cracks. We know it's happening; you've heard all this. My plea is that we don't just keep doing the same thing over and over again. We have to do something different. People

say it's the definition of madness to keep doing the same thing over and over again and expect a different outcome. I'm a psychiatrist. It's not the definition of madness but it is of silliness, to do that.

Mr. Jeff Leal: Well, in this committee, I think, it's our intention to forge a new course.

The other question I have—I'll be brief. The role of LHINs in the province of Ontario in terms of mental health planning: Do you have any thoughts on that?

Dr. Richard O'Reilly: Not really, but again, my ask to the committee is to make sure that the LHINs do not allow the government to walk away from making sure that the money's used accountably, particularly money that's tied to the treatment of serious and persistent mental illness.

Mr. Jeff Leal: Okay. Thank you, Doctor.

The Vice-Chair (Mrs. Christine Elliott): Mr. Ramal, I believe you have a question as well.

Mr. Khalil Ramal: Yes, a quick question. Thank you very much, Dr. O'Reilly. I know you have been pushing for a long time for changes in the Mental Health Act. You mentioned also non-controversial changes would affect many different people in a positive way. You don't think these changes might help someone; that in the end, in some different cases, they will affect the rights of individuals? I know you've dealt with many different cases and you've been passionate about it for many years.

Dr. Richard O'Reilly: Let me first say that we have a great organization in Ontario called the Psychiatric Patient Advocacy Office. They provide rights advice and other services, getting individuals lawyers so that they can challenge civil commitment and findings of incapacity. It's really wonderful.

I'm suggesting a change. In coming before this committee, I have looked at the likely outcome of the change. In fact, the outcome of the change is—that only one person in Ontario, over a 15-year period, would have been given a medication that she didn't want while in hospital.

On the other hand, the outcome would be that many, many individuals—actually hundreds—would be discharged earlier from hospital and some would avoid periods of involuntary detention in hospital lasting many years—up to 25 years in one case.

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Mr. Khalil Ramal: Just a quick one: You talk about the system having some kind of flexibility but that flexibility not being used by some doctors. Can you tell us why? What's the reason it's not being used? You mentioned that when you answered some questions in terms of responsibility of the parents, that they look after the person financially and also administer the drugs.

Dr. Richard O'Reilly: I think there are many problems. I think, in one of my responses, it was on the issue of releasing information. I think that's a lack of knowledge. It's a significant problem with that. I don't think that many of my colleagues know about that or have really seriously considered it. When they don't consider

it, and they are teaching the new generation coming through, then they don't consider that either. That's one problem.

But I think there are other problems. In the general hospitals, we have a fee-for-service system. A fee-for-service system doesn't suit the management of people with very severe and persistent mental illness, who are going to be applying for review boards on a frequent basis and whose behaviour, in other ways, leads to needing to spend a lot of time talking to group home managers, case managers, the police etc.

There are other things. It's a complex potpourri of reasons, but those are two important ones.

Mr. Khalil Ramal: Thank you.

The Vice-Chair (Mrs. Christine Elliott): I have one question, just to finish off. My question really relates to the person who lacks insight into the fact that they have a problem and what happens, the frustration that's been expressed by families, physicians and police with multiple admissions: that people maybe go in, they're committed on a form 1 for a period of 72 hours and then, at the end of the time, if they're not actively suicidal or homicidal—to be a little bit simplistic about it—then they're discharged, and it's just a revolving door that results in multiple admissions. I'd really be interested in your insights, Dr. O'Reilly, on what you think we could do to stop that, whether an earlier capacity assessment, while the person is there on the form 1, would be helpful or what you would suggest instead.

Dr. Richard O'Reilly: Madam Chair, our Health Care Consent Act and Mental Health Act actually require an assessment of capacity—in fact, ongoing assessment of capacity, but particularly when someone's admitted to a psychiatric ward.

An assessment of capacity doesn't need to be a prolonged thing. It can be done when you're sitting down with a patient. If a person is incapable of consenting to their treatment, if they are likely to deteriorate either mentally or physically because of their mental illness, and if they have previously been treated and responded to the treatment, they can actually be kept in hospital with the substitute decision-maker's agreement and agreement to provide treatment. This is the so-called "box B" criteria, or deterioration. We already have this in our act; it could be used much more.

Our problem, and the problem that my colleagues face, is a problem of overcrowding in the wards: beds full and no room at the inn when we have patients in this situation. Many patients would benefit from being admitted under the box B criteria and treated just in the situation. That's an area that you outlined.

The Vice-Chair (Mrs. Christine Elliott): This is the first time I've heard that we already had the ability to do that. My question is, why aren't families availing themselves of that opportunity, then, to say, "I'm going to choose since my son or daughter or family member is deemed to be incapable of personal care decisions"? Why can't they step in as either the explicit substitute decision-maker or de facto substitute decision-maker if one hasn't already been selected?

Dr. Richard O'Reilly: Well, they are the substitute. There's a hierarchy, and most times the family member falls in that and is the person designated by the hierarchy. The problem is that that doesn't give the family member the right to admit somebody to hospital. That rests with the physician, and the physician doesn't have the ability to admit someone to hospital if there are no beds.

In a typical emergency room on a Friday or Saturday night, there are maybe five, six or seven people who are psychotic and would benefit from treatment, but there are no beds upstairs in the ward. So then, it often becomes a triaging exercise to shelters and other inappropriate places, with a small prescription of medication and an appointment to return to some outpatient service in the following week.

The Vice-Chair (Mrs. Christine Elliott): So this is a far more serious issue than—the lack of beds is really preventing substitute decision-makers from asking that someone be treated, and the physician theoretically can't admit them because there are no beds, rather than a lack of ability to deal with it in a legal sense.

Dr. Richard O'Reilly: Absolutely. There are the provisions in our act; I think some of them we may question, and certainly there is concern among some families about the requirement for prior treatments before the box B deterioration criteria can be invoked. It could be invoked for many—many patients would benefit from it—but there are no beds to put those patients in.

The Vice-Chair (Mrs. Christine Elliott): I think Ms. Jaczek has one further follow-up.

Ms. Helena Jaczek: Could I just follow up on this? Because I know that when we looked at the legislation—and I don't have it in front of me—first of all, there was this issue of if this was the first episode; obviously, part of the wording didn't apply. It seemed that you had to have gone through this before; treatment had been successful before. Therefore, in this instance, you wanted treatment again because it had been proven to be helpful. So that's a bit of an issue, if this is a first break.

There was also wording that seemed to imply bodily harm. Wasn't there an issue with how the wording didn't seem to imply mental deterioration? The wording seemed to imply that you had to do yourself some physical harm. Anyway, that was the way it seemed to read to us.

Dr. Richard O'Reilly: In Ontario, if I am to commit someone because they are at risk of substantial mental or physical deterioration, then I have to have a number of other things. I need the consent of the substitute decision-maker, the person must have previously had treatment and responded, but the bodily harm doesn't come into that. The bodily harm issue is related to the other criteria.

Without the permission of the substitute and without the need for somebody incapable of actually consenting for their own treatment, a physician can admit a patient if they are a danger to themselves or to others, or at risk of substantial physical impairment, which basically means that unwittingly, because of a mental illness, they will suffer serious bodily harm, such as sleeping out and getting frostbite or wandering in traffic because of inattention due to their mental illness. I hope that's—

Ms. Helena Jaczek: So that wording really could be used in the first instance because the physician could assume that this person is out of touch with reality, it's minus 40 degrees and they might wander out, and therefore, "I can use that provision to initiate treatment."

Dr. Richard O'Reilly: Well, in Ontario, we separate hospitalization from treatment. You could use the provision in the first instance to admit a person and you would not need to contact the substitute decision-maker. Then the physician must assess the person's capacity to consent to treatment or refuse treatment. If that's absent, they could be treated. Of course, a person with a mental illness who is going to do that—sleep out when it's minus 40—should receive treatment.

The Vice-Chair (Mrs. Christine Elliott): Thank you very much, Dr. O'Reilly. We really appreciate your presence here and your answering our questions. If we do have any follow-up questions, would it be all right if we are able, as a committee, to contact you?

Dr. Richard O'Reilly: I would be absolutely delighted to provide any further information that the committee wants or answer any further questions that may come up after your deliberations.

The Vice-Chair (Mrs. Christine Elliott): That's terrific. We greatly appreciate that. Thank you again for joining us today.

Dr. Richard O'Reilly: Thanks very much.

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M. ANDRÉ MARCIL

The Vice-Chair (Mrs. Christine Elliott): Our next presenter is André Marcil. Mr. Marcil, please make yourself comfortable. There's water there. Get yourself settled and start whenever you're ready.

For the information of the committee members, while the next presenter is getting set up, for any of you who have received the brown envelope—that's for those of us who are travelling to Peterborough on Friday—it contains some information, and Susan has also provided us with the revised itinerary. If I could just ask you to make sure you make note of that so that we're all in the right place at the right time and the bus doesn't leave us stranded somewhere. That is all for that.

M^{me} France Gélinas: I had memories of Sioux Lookout when you were talking about the bus leaving.

The Vice-Chair (Mrs. Christine Elliott): Oh, yes. There was that.

M^{me} France Gélinas: I knew that has happened to somebody at some point.

M. André Marcil: Alors, on attend que l'ordinateur soit prêt. Je pense que vous saviez—ce n'est pas une surprise—que j'aurais une présentation.

Interjection.

M. André Marcil: Je disais que j'ai été invité pour vous faire une présentation en français, étant donné que ça touche à l'accès à des services de santé mentale et de lutte contre les dépendances pour les francophones en Ontario, et plus précisément pour la région du Nord-Est.

Je vais essayer de ne pas parler trop vite pour donner une chance aux traducteurs. Ma présentation va évidemment être en français.

J'ai sept sections dans cette présentation :

- évidemment, l'introduction;
- la question de l'accès à des services en français de qualité—c'est une question d'équité et de droits;
- l'état de la situation en général au niveau de l'accès à des services de santé en français de qualité dans le nord-est de l'Ontario. C'est quoi l'état, en général, de l'accès?;
- la démographie de la population francophone du Nord-Est;
- l'accès à des services de santé mentale et de lutte contre les dépendances en français de qualité dans le Nord-Est;
- les pistes de solutions; et
- les pratiques exemplaires à considérer pour améliorer l'accès.

Je vais vous parler de l'accès, des lacunes, mais aussi des solutions possibles en tenant compte des ressources existantes.

La première chose que j'aimerais vous dire est que je vous remercie de m'avoir donné l'opportunité de participer à ce grand projet, qui est de réformer le système et d'améliorer l'accès à des services de santé mentale et de lutte contre les dépendances en Ontario.

Je dois vous dire que ça fait 26 ans que je travaille dans le système. J'ai participé à plusieurs comités sur la planification. Quand je regarde le document que vous avez développé, Chaque porte peut être la bonne porte, je regarde la vision, les objectifs, les sept orientations stratégiques, la stratégie d'aller au-delà des services de santé mentale spécialisés, de tenir compte des autres services comme les soins primaires, d'aller encore au-delà de la santé vers les autres ministères qui offrent des services à la clientèle qui souffre d'un problème psychiatrique. Je dois vous dire que je trouve que c'est la meilleure stratégie que j'ai vue qui a été proposée en Ontario jusqu'à maintenant.

Maintenant, les propos, ce pourquoi je suis ici, comme je le disais tantôt, est de regarder l'accès aux services en français de qualité avec vous autres, tout en mettant l'accent sur le fait que c'est un grand défi qu'on a tous à relever ensemble. Je pense qu'une fois qu'on aura passé à travers les premières parties sur les données, l'information sur l'accès ou le manque d'accès, ça va vous donner un meilleur portrait de ce que je veux dire par « défi ».

Je suis sûr que vous êtes au courant, mais j'aimerais tout de même débiter en parlant de la question d'équité et de droits. Comme vous le savez, le français est une des deux langues officielles au Canada. Alors, elle repose sur plusieurs assises juridiques. La première, comme vous le savez, c'est le principe constitutionnel du respect et de la protection des minorités : la Loi sur les langues officielles du Canada, et la Loi sur les services en français de l'Ontario, qui, après la cause de Montfort, comme vous le savez, est une loi maintenant quasi

constitutionnelle. Cela veut dire qu'elle a préséance sur les autres lois de la province. Il y a aussi la Loi de 2006 sur l'intégration du système de santé local, qui stipule les obligations du gouvernement et de tout le système de santé Ontarien en vertu de la Loi sur les services en français, qui est maintenant, comme je le disais, une loi quasi constitutionnelle.

Ceci dit, les francophones en Ontario ne sont pas un groupe ethnique parmi d'autres. Les francophones en Ontario sont un peuple fondateur. Ce que ça veut dire, c'est qu'ils ont des droits, puis c'est une question d'équité et de droit d'avoir accès à des services de qualité en français. Toutefois, comme l'a indiqué Maître François Boileau, le commissaire aux services en français de l'Ontario, dans son rapport sur la planification des services de santé en français de 2009 : « On ne dessert pas la clientèle francophone en français parce que l'on est obligé de le faire. On le fait parce que ça améliore directement la santé des gens; c'est tout simplement la meilleure chose à faire. »

L'accent de ma présentation est surtout sur ce dernier point-là. Ce n'est pas nécessairement le point juridique, mais c'est plutôt de faire appel à la compréhension, à l'état de la situation par rapport aux francophones. C'est ce que je vais tenter de faire.

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L'état de la situation au niveau de l'accès à des services de santé en français de qualité, un aperçu général : le Comité consultatif des communautés francophones en situation minoritaire a estimé, en 2001, que plus de 50 % de la population francophone minoritaire avait peu ou pas d'accès à des services de santé en français. En appui, les rapports de Beaulieu et Lalonde de 2003 et de Louise Picard et Gratien Allaire en 2005 indiquent que l'Ontario n'arrive pas à offrir à sa minorité les services dont elle a besoin et que le niveau de qualité des services est loin d'être comparable à ceux offerts à l'ensemble de la population de l'Ontario.

D'autres enquêtes révèlent que 40 % à 80 % des personnes aux prises avec des problèmes de santé mentale ou de toxicomanie—ou de dépendance, si vous préférez—ne reçoivent absolument aucun traitement.

Toutes les annotations que vous avez—les références—sont toutes dans le document que je vous ai donné. Je vous ai donné un document dans une pochette. Ce document-là est complet; tout est là. La présentation « PowerPoint » est juste des extraits que j'ai repris, mais toutes les listes d'études auxquelles je me réfère, vous avez toutes les références pour aller les vérifier et les consulter.

De plus, dans les hôpitaux, le service d'urgence, comme on le sait, est souvent le point central d'accès au système de soins de santé où les trois quarts des Franco-Ontariens se voient refuser l'accès à ce service dans leur langue. Alors, il y en a trois quarts, 75 %, qui, quand ils vont à un service d'urgence en Ontario, n'ont pas accès à des services dans leur langue.

Au niveau de la barrière linguistique, le Rapport spécial sur la planification des services de santé en

français en Ontario, 2009—c'est encore une fois du commissaire—identifie les effets découlant des barrières linguistiques comme suit : cela engendre des effets négatifs sur la qualité des services, l'efficacité et l'efficacité du système de santé. Ça réduit le recours aux services préventifs, influence la qualité des services où la bonne communication est essentielle—et quand on parle de santé mentale, on parle de communication, on parle de compréhension. On ne parle pas juste de compréhension de la langue, mais on parle de compréhension de la culture, ce qui fait qu'un francophone ou un anglophone ou n'importe qui d'autre qui appartient à un groupe spécifique a développé des façons de penser, des valeurs communes, etc.; alors, la question est de comprendre les cultures.

Cela augmente aussi le temps de consultation. Alors, quand on veut prendre une consultation et qu'on est francophone, et on est desservi, par exemple, par un psychiatre anglophone, le temps de consultation peut être un peu plus ardu, parce qu'il y a de la difficulté dans la communication.

Ça peut être difficile aussi au niveau des tests diagnostiques. Nous, on a vu ça. À l'organisation pour laquelle je travaille depuis 25 ans, qui offre toute une gamme de services de santé mentale, on a souvent vu et on a pris connaissance des cas où il y a des gens qui avaient eu des diagnostics et c'était vraiment une erreur due à la langue et à la compréhension de ce que l'individu, le client, donnait au psychiatre.

Alors, ça dit, les « tests diagnostiques et la probabilité d'erreur dans les diagnostics et les traitements »—ça diminue également la probabilité de fidélité aux traitements et réduit la satisfaction à l'égard des soins et services reçus. On va voir un professionnel de la santé pour une dépression. On ne se sent pas vraiment compris, puis il nous prescrit des antidépresseurs, mais ça se peut que ça nous ne tente pas de prendre des antidépresseurs parce qu'on n'est pas sûr qu'on était compris, que c'est vraiment ce traitement-là qui va nous aider.

D'autres études viennent appuyer les propos du commissaire dans le rapport d'évaluation de Santé Canada de 2008. Ce rapport-là présente les résultats d'une revue de 135 études portant sur la langue comme barrière de communication. Ce n'est pas juste parce que moi, je l'ai dit aujourd'hui; c'est basé vraiment sur plusieurs études.

En santé mentale, trois études, entre autres, montrent que les patients confrontés à des barrières linguistiques semblent présenter davantage des symptômes d'une maladie mentale, ou, ça augmente les symptômes.

D'autres études confirment que les locuteurs d'une langue minoritaire sont notamment plus susceptibles de recevoir un diagnostic erroné—comme j'ai donné dans mon exemple tantôt—par rapport à leur condition, et donc un traitement inapproprié.

Si les intervenants en santé ne comprennent pas clairement les patients et que ceux-ci ne se sentent pas à l'aise dans cette relation, ils auront tendance à moins utiliser les services disponibles.

D'autres soulignent que le problème de barrières linguistiques va au-delà de l'intervenant, soit au niveau organisationnel. « Ce n'est pas que l'intervenant qui doit posséder les compétences culturelles, mais l'ensemble du personnel des organismes et du système... »

Je vous donne un exemple : vous avez une organisation qui est désignée sous la Loi sur les services en français. Alors, on sait que dans une désignation, si la désignation est complète, ça veut dire que tout le monde est capable de bien servir en français ou dans les deux langues. On peut avoir un individu qui va rencontrer un travailleur social et va être desservi en français. Il a besoin de voir l'infirmière, qui est unilingue anglophone, et le psychiatre est unilingue anglophone. Est-ce qu'on peut vraiment parler d'un service qui est accessible dans un français de qualité? Permettez-moi d'en douter.

La langue et la culture, un déterminant de la santé pour les francophones de l'Ontario : dans le rapport du commissaire 2009, celui-ci indique que « les normes de santé publique de l'Ontario reconnaissent que la langue et la culture sont des déterminants de la santé... ». Le commissaire précise que les francophones de l'Ontario ont des besoins spécifiques et des caractéristiques qui leur sont propres, et lorsqu'ils reçoivent des services de santé dans leur langue et leur culture, leur santé s'améliore. Dans le cas contraire, la santé a tendance à se détériorer.

La langue et la culture, un déterminant de la santé, suite : D'autres études ont démontré que la santé, en général, des francophones en Ontario est moins bonne que celle de la majorité; ils sont plus à risque en ce qui à trait à plusieurs comportements qui touchent la santé. Il y a deux études qui sont principales, dont vous avez les références dans le document.

Plusieurs autres études ont démontré que les services offerts étaient de meilleure qualité lorsque les communautés touchées s'occupaient davantage de leur santé. Alors, quand c'est des francophones qui offrent des services aux francophones, évidemment, les services sont adaptés aux besoins des francophones, puis ils y ont accès dans un français de qualité.

Ceci m'amène au nord-est de l'Ontario. Le Nord-Est est une région que je connais mieux, alors mes propos vont plus cibler le Nord-Est. Le nord-est de l'Ontario englobe 40 % du territoire de l'Ontario. C'est un territoire immense avec une population totale d'environ 551 691 individus, dont 125 000 francophones, qui représentent 23,1 % de la population qui est répartie dans six districts.

La population francophone qui est répartie sur ce vaste territoire-là se retrouve aussi en grand nombre dans certaines régions, alors un grand nombre par une plus grande proportion. Je veux vous montrer ça ici. Le tableau vous présente—si vous regardez dans les districts, il y a quatre districts principaux où on retrouve un plus grand nombre de populations francophones. Il y a le district de Cochrane, Manitoulin-Sudbury, Nipissing, puis Témiscamingue.

Dans le district de Cochrane on retrouve 49 % de la population qui sont des francophones de langue

maternelle. Ça veut dire que la population francophone est majoritaire dans le district de Cochrane, parce qu'on a évidemment les anglophones, mais on a aussi des autochtones. Alors c'est le district dans le Nord-Est où les francophones sont majoritaires. Ensuite, on a Manitoulin-Sudbury, où on trouve 25 % de la population, qui est quand même 50 000, comparativement à Cochrane, qui n'est pas loin de 40 000; le Nipissing, 20 000, qui représente 24,7 % de la population; puis le Témiscamingue a 8 000, qui est 24,5 % de la population.

Une chose qui est à noter et qui est vraiment importante pour la planification future est que 50 % des francophones dans le Nord-Est en 2006 avaient 40 ans et plus. Alors, ça veut dire que la population est vieillissante, donc ça veut dire qu'il y a des soins de santé qui vont devenir plus évidents. Aussi, c'est la tranche d'âge où l'anglais est le moins maîtrisé. Les gens ont plus de difficultés à fonctionner en anglais.

Maintenant, pour ce qui est de l'état de la situation dans le Nord-Est, on peut se poser la question : « Où sont les services de qualité en français qui seraient accessibles? » Moi, j'ai utilisé trois sources principales d'information pour savoir ça : la qualité et l'accessibilité des services en français dans le Nord-Est. Premièrement, j'ai utilisé la liste des fournisseurs de services de santé du RLSS pour les organisations soit qui ont manifesté le désir d'être désignées, ou qui sont partiellement désignées ou qui sont désignées. J'ai aussi utilisé le plan de services intégré du RLSS pour identifier le nombre d'organisations. Je pense que c'est assez significatif, ce que vous allez voir comme information. J'ai donné les nombres, maintenant on va les regarder.

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En santé mentale, sur 40 organisations qui offrent des services de santé mentale communautaires sur ce grand territoire, quatre sont désignées pour desservir une population de 125 000 personnes francophones, tout en étant aussi mandatées pour desservir la population anglophone—alors, quatre pour toute cette grande région-là.

Dans le domaine de la lutte contre les dépendances, sur 10 organisations, il y en a quatre qui sont désignées, dont trois qui sont des organisations francophones. Si je reviens à la santé mentale, il y en a une qui est une organisation francophone, sur les quatre.

En ce qui a trait aux services hospitaliers, sur 26 hôpitaux locaux, trois sont désignés, et deux partiellement. Tantôt, les statistiques générales disaient que 75 % des francophones qui vont à l'urgence ne sont pas capables d'être desservis en français, mais si on regarde ici le Nord-Est, sur 26 hôpitaux, il y en a trois désignés, puis deux qui le sont partiellement.

Je peux vous dire que dans ma région, il y en a un qui est désigné, mais quand je vais à l'urgence avec mes enfants ou pour moi, je suis toujours desservi en anglais. Alors, il faut faire attention à ce que ça veut dire, « désigné ». Est-ce qu'on veut dire une désignation complète ou pas? La plupart du temps, ça ne veut pas dire une désignation complète. Quelles sont les façons

d'évaluer si vraiment les organisations désignées offrent des services qui sont de qualité en français et qui sont accessibles en tout temps? Ça, c'est une toute autre question.

La deuxième et la troisième source d'information sur l'accès pour les francophones dans le Nord-Est à des services de santé de qualité proviennent des rapports Préparer le terrain: rapports régionaux du Nord et du moyen Nord, et de notre expérience à titre de pourvoyeur de services. Ces rapports-là nous informent que les services de santé en français, incluant les services de santé mentale et de lutte contre les dépendances, présentent une variation des niveaux, les services allant de faible à adapté aux besoins sur le territoire. Si c'est un grand territoire, il y a des places où on a des services qui sont plus adaptés aux besoins, puis à certains endroits il n'y en a pas. On va qualifier un petit peu tout ça.

Cette tendance a aussi été identifiée au niveau de l'accès aux soins de santé offerts par les hôpitaux locaux et les pourvoyeurs de soins de santé primaires offerts par des organisations de gouvernance francophone. Alors, quand ils ont une gouvernance francophone, évidemment, les services sont accessibles en français de qualité et répondent aux besoins.

Dans le Nord-Est, on a deux hôpitaux qui sont de gouvernance francophone : on a l'Hôpital Notre-Dame, puis on a l'Hôpital de Smooth Rock Falls. Un petit peu plus loin, je vais parler un petit peu plus des pourvoyeurs de soins de santé primaires qui offrent des services en français.

À l'inverse, par contre, l'accès est plus limité avec les hôpitaux locaux et les pourvoyeurs de soins de santé primaires de gouvernance anglophone. Pourquoi est-ce que c'est limité? C'est caractérisé par un manque prononcé de médecins francophones ou bilingues. L'accès à d'autres professionnels de santé, dont les pharmaciens—vous savez que quand vous allez voir votre pharmacien, puis il vous explique comment prendre un médicament, puis il ne vous parle dans votre langue et vous avez de la misère à comprendre, vous avez un problème. On en voit, de ça. Même chose—accès à une infirmière. Ce n'est pas toujours disponible en français. Même la plupart du temps, ça ne l'est pas dans les institutions qui sont anglophones.

L'état de la situation dans le Nord-Est, suite : le rapport de la région du Nord appuie les observations que je viens de faire, en soulignant : « Les communautés du Nord-Est affirment, en général, recevoir peu de services en français, sauf quand il s'agit d'un service géré et offert entièrement par des francophones ».

En ce qui a trait à l'accès à des services de santé mentale de deuxième et de troisième lignes—là on parle des hôpitaux de district qui ont des départements de psychiatrie, et de « troisième ligne » on parle des hôpitaux psychiatriques—le manque d'accès à des services en français de qualité est flagrant. Puis je vais vous donner un peu plus d'information au fur et à mesure.

Sur les cinq hôpitaux de district offrant des services de santé mentale de deuxième ligne, un seul est désigné,

mais la plupart du temps, quand on y envoie nos clients francophones, ils ne sont pas desservis en français. On va vous présenter un cas tantôt qui va bien illustrer ce qu'on veut dire par cela.

« Désigné », ça veut dire ce que ça veut dire, avec les limites que cela a. Les quatre autres ne sont pas désignés, donc il n'y a pas de services en français, ou très peu.

En ce qui a trait aux services de troisième ligne, ils sont offerts par le Centre de santé mentale du Nord-Est, dont la majorité des programmes ne sont pas accessibles en français. Par exemple, de 13 programmes régionaux de liaison communautaire qu'il gère, un programme, soit le programme de psychogériatrie, avec lequel on travaille conjointement, est supervisé par un gestionnaire bilingue francophone, et les services cliniques sont offerts par un psychiatre itinérant francophone. Ça fonctionne bien. Les gens ont des services de qualité en français. Le Centre de santé mentale du Nord-Est a un programme gagnant—un, sur tous les autres. Alors, ça serait une belle histoire à répéter. On en parlera tantôt aussi.

Ça m'amène aux histoires de cas. Pour ceux qui peuvent suivre en français, dans le document que vous avez, à la page 5, j'ai commencé par une première histoire de cas qui concerne l'accès à des soins de santé primaires. C'est une situation qui est arrivée chez nous. Voici le cas d'un client qui s'est présenté en détresse chez son médecin. Ce client francophone explique au médecin anglophone du mieux qu'il peut en anglais qu'il ne va pas bien; qu'il fait de l'automutilation; qu'il se fouette par remord ou culpabilité en lien avec son passé. Le médecin ne peut pas capter correctement tout ce que le client en détresse lui dit, et conséquemment aucune intervention n'est faite par rapport à cette crise par le médecin. Les éléments dépressifs, d'estime de soi, de culpabilité et de dangerosité pour le patient et potentiellement pour les autres sont restés inexploités.

Qu'est-ce qui est arrivé? Plus tard, ce client, toujours en détresse, est retourné chez lui et tente de mettre fin à sa vie en utilisant une bouteille de boisson gazeuse brisée pour se perforer l'abdomen à quelques reprises. Ce client est encore vivant aujourd'hui mais cette tragédie aurait pu être évitée si le médecin traitant aurait été en mesure de comprendre le français et le client en détresse aurait pu s'exprimer et être compris dans sa langue. L'intervenant primaire de ce client a fait un suivi avec le médecin, qui a confirmé n'avoir pas saisi les propos du client lorsque le client s'est présenté en détresse.

Alors, ce qu'on dit, c'est que souvent, des clients doivent être accompagnés d'un membre de famille ou d'un ami afin d'obtenir de l'aide pour effectuer la traduction. Ceci ajoute un stress additionnel au client, ayant à dépendre sur une troisième personne afin d'essayer d'obtenir des soins adéquats d'un médecin, puis ça aussi cause des problèmes. Les gens qui font de la traduction sans avoir nécessairement les compétences pour le faire : ça fait partie d'un autre aspect que je présenterai un petit plus loin.

Nous pouvons résumer nos observations sur le manque d'accès à des services en français de qualité en

corroborant plusieurs éléments identifiés dans les rapports régionaux du Nord et du Moyen Nord comme suit—c'est une série de constats qui résument ce que je vous ai présenté jusqu'ici, mais d'une façon succincte :

Premièrement, l'accessibilité à des services de santé mentale et de toxicomanie en français de qualité est une exception que l'on retrouve surtout dans le nord du district de Cochrane. Ce service n'est donc pas continu sur tout le territoire.

Dans les autres districts, la majorité des services sont accessibles via les organisations offrant des services de santé mentale et de lutte contre les dépendances, les cabinets de médecins et les hôpitaux, qui sont tous presque exclusivement en anglais, sauf dans les endroits où il y a des centres de santé francophones et des équipes de santé familiales francophones où un accès limité est offert à des services de base en santé mentale.

Les services spécialisant en santé mentale de deuxième et de troisième lignes ne répondent pas adéquatement aux besoins des communautés francophones du Nord-Est, puisqu'ils sont accessibles presque exclusivement en anglais.

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J'aimerais partager deux autres cas. Page 6, dans le bas : un cas assez pathétique. Un homme dans la soixantaine, schizophrène, en phase psychotique, ayant des hallucinations auditives avec idées de persécution et des idées suicidaires, se présente à l'urgence de l'hôpital local. Suite à l'évaluation, il est transféré à l'hôpital du district de Timmins. Monsieur est incapable de s'exprimer en anglais. Il ne peut recevoir de l'aide pour ses besoins psychiatriques. Il reste à l'hôpital du district de Timmins quelques jours et il est retourné à la maison. Lors de ce séjour, la conjointe, qui est aussi souffrante d'un problème de santé mentale à long terme et grave, n'a pu obtenir de l'information au sujet de son conjoint car elle ne comprend pas l'anglais et que le personnel de l'hôpital, à ce moment-là, n'était pas en mesure de communiquer en français—un hôpital désigné, encore une fois.

Toujours instable, le client en question est retourné de l'hôpital à la maison. Par la suite, les services ont tenté de mieux aiguiller le client vers des ressources francophones pour qu'il puisse être desservi. Le client exprime ne plus vouloir retourner à l'hôpital de Timmins. On peut comprendre. Les arrangements sont donc effectués avec l'Hôpital Montfort d'Ottawa. Le client est réticent d'aller à Montfort, parce que c'est quand même à 1000 kilomètres de chez lui, mais finalement il coopère parce qu'il sait qu'il va recevoir des services dans sa langue. Il se rend donc à Montfort et y passe un séjour de quelques semaines. Une fois que son statut mental a été stabilisé, le client est retourné à domicile, et il était satisfait des services : un exemple de client qui a eu accès à des services de deuxième ligne dans sa langue appropriée, et qui a pu retrouver un statut de santé mentale normale et fonctionner.

Le troisième cas, c'est un cas qui est arrivé en 2002, vraiment intéressant. Ça concerne les services de

troisième ligne. Ce jour de 2002, où les professionnels de la santé de l'hôpital psychiatrique de North Bay se sont rendus à Kapuskasing, dans le Nord, avec l'un de leurs patients, ils ne s'attendaient sûrement pas à connaître la plus grande surprise de leur carrière. Leur patient était transféré à la charge des services de counselling. Il rentrerait chez lui à Kapuskasing afin de vivre au sein de la collectivité. Conformément au protocole, les membres de l'équipe de North Bay ont transmis à leurs collègues de Kapuskasing les renseignements pertinents sur le patient avant de le leur confier. Ils ont indiqué que le patient était très renfermé et qu'il parlait à peine. Le conseiller en chef de Kapuskasing, qui était à ce moment-là avec le patient et l'équipe à Kapuskasing, s'est alors adressé directement au patient, en français. Les professionnels de l'équipe de transfert de North Bay ont été stupéfiés d'entendre le patient parler plus qu'il ne l'avait jamais fait, et de s'engager dans une véritable conversation. On s'était adressé à lui en français. Ce patient s'est depuis lors adapté, et il vit dans la collectivité de Kapuskasing, dans une région qui est francophone à plus de 72 %. C'est donc dire qu'il avait vécu sept ans à l'hôpital psychiatrique de North Bay, et pendant ces sept années, il avait été traité par des médecins et des professionnels de la santé qui s'adressaient à lui exclusivement en anglais. Encore en 2010, l'équipe me disait hier, les soins sont livrés presque exclusivement en anglais.

Alors, quand on dit que les services de deuxième et troisième lignes ne répondent pas adéquatement aux besoins des francophones, vous avez des exemples qui le démontrent. Non seulement la littérature nous le démontrait, mais les exemples pratiques chez nous dans le Nord-Est sont là. Vous avez les nombres d'institutions qui sont disponibles à offrir des services en français; il y en a très peu.

D'autres problèmes que vous avez bien identifiés aussi dans votre rapport : la pénurie de professionnels de santé mentale et de lutte contre les dépendances, compétents linguistiquement et culturellement—et le manque d'accès à des programmes de formation continue en français pour les professionnels.

La qualité des services est souvent compromise : lorsque les institutions ou les professionnels de la santé ont recours à un interprète, comme un employé de soutien ou un membre de la famille, pour faire la traduction des besoins du patient, de ses problèmes de santé mentale—ce n'est pas très adéquat—et lorsque des documents sont traduits de l'anglais au français sans tenir compte de la validation linguistique et culturelle.

En ce moment, comme vous le savez, il y a un instrument qui s'appelle OCAN, Ontario Community Assessment of Need, que le gouvernement veut implanter un peu partout. Nous, on est un projet pilote en Ontario et notre organisation est la première organisation à être comme projet pilote pour utiliser cet instrument-là. Je dois vous dire que quand on prend un instrument qui a été validé de façon psychométrique—fidélité et validation—dans une langue, donc qui est efficace, qui est prouvé statistiquement comme fonctionnel, et qu'on

fait tout simplement traduire et véhiculer dans une autre langue, on vient de faire quelque chose qui n'était pas très approprié, parce que quand on veut utiliser des instruments qui sont psychométriquement valides, il faut qu'ils soient validés. Si on cherche en ce moment, le seul endroit où on peut faire valider des instruments comme ceux-là, c'est à travers l'Hôpital Montfort. Il y a un département où ils font de la recherche et font la validation d'instruments.

Nous, on a un instrument—justement j'en parlais la semaine dernière avec un des employés qui l'utilisent—où on a des questions qui ne font pas de sens; eux, ils interprètent la question comme ils la comprennent, mais vous savez que quand une question ne fait pas de sens pour un interprète, c'est une interprétation d'une autre interprétation. Il faut faire attention d'avoir des instruments qui sont validés, pas juste des traductions.

Le manque de compréhension et de sensibilité dans des institutions à majorité anglophone, face à l'importance pour les francophones de recevoir des services dans leur langue maternelle—c'est ce que plusieurs ont remarqué.

Il y a un nombre insuffisant de francophones occupant des postes de cadre et siégeant sur les conseils d'administration d'organisations et d'institutions de santé.

Le manque d'information sur les services en français disponibles : on parle d'offres actives. Il n'y a pas trop d'offres actives, à moins qu'on ne soit avec des organisations de gouvernance francophone qui offrent des services en français.

La quasi-inexistence de programmes en français de promotion d'une saine santé mentale et d'éducation concernant la prévention et la gestion des maladies mentales—un constat que vous aviez fait aussi dans votre rapport, comme quoi il n'y avait pas de programmes de façon systématique pour faire de la prévention et de l'éducation sur la santé mentale.

Une chose qui est importante aussi, si on veut être capable de planifier pour un groupe, de savoir quels sont les besoins d'un groupe pour bien cibler la réponse à ces besoins-là : ce qu'on constate partout en Ontario, c'est le manque de données sur l'état de santé, incluant la santé mentale, de la population francophone. Sur les besoins des différentes collectivités francophones, j'ai des données, mais ce ne sont pas des données spécifiques; c'est-à-dire, on ne parle pas de prévalence des maladies, on ne parle pas du nombre de professionnels francophones de spécialisation, on ne recueille pas de façon intégrée, dans les différents systèmes d'information, la même information qu'on va recueillir pour la majorité. Donc, la collectivité francophone a des besoins spécifiques, mais ces besoins spécifiques-là, le système ne va pas les collecter.

On a un commissaire de l'Ontario qui nous dit que ces déterminants de santé des francophones—on a des besoins spécifiques, mais on a un gros manque au niveau de systèmes de données pour aller chercher de l'information.

Une autre chose qu'on devrait remarquer, c'est l'absence d'un cadre d'imputabilité adéquat quant aux

services de santé en français bien définis et bien appliqués. Ça veut dire des règlements administratifs, des indicateurs de rendement spécifiques aux services de santé en français intégrés, des ententes de rendement et des contrats conclus entre le RLISS et le ministère de la Santé. Nous, on pense que, tant qu'il n'y aura pas ça, ça ne fonctionnera pas. On prend encore l'exemple de TDH, hôpital désigné avec un département de psychiatrie. C'est une place où c'est important de pouvoir communiquer dans la langue et la culture. C'est un hôpital désigné. Il faudrait peut-être qu'on vérifie pour voir s'ils ont vraiment les ressources requises pour desservir leur clientèle francophone. Sinon, il y a peut-être quelque chose qui devrait être fait.

Les pistes de solutions—parce qu'il y en a, des solutions. Il y en a déjà qui ont commencé à être mis en marche par le gouvernement de l'Ontario et le RLISS du Nord-Est.

Dans son rapport de 2009—à ce moment-là, il y avait certains gestes qui n'avaient pas été posés, puis vous allez voir après qu'ils viennent les bonifier—le commissaire indique à ce sujet que le ministère de la Santé et les 14 RLISS « doivent travailler de pair avec la communauté francophone afin d'améliorer la prestation des soins de santé aux francophones ... en ce qui a trait à la planification et l'accès aux soins de santé ».

À cet effet, le commissaire précise que « l'un des facteurs déterminants dans l'amélioration de la santé et du bien-être d'une communauté passe par sa capacité à prendre en charge son développement. Cela implique donc qu'elle doit être impliquée dans la planification et dans la gouvernance de ses propres soins de santé locaux »—qui ne veut pas dire de mettre en place des modèles parallèles aux niveaux primaire, secondaire, puis tertiaire, je vous rassure tout de suite, mais qui ne veut pas dire non plus de ne pas mettre en place certains services en français.

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Bien que le rapport du commissaire utilise l'exemple du modèle du centre de santé communautaire, ses propos s'appliquent aussi au centre de santé mentale et de toxicomanie communautaire à gouvernance francophone. Alors, on va prendre les propos : ils sont « des preuves tangibles de la vigueur et de la vitalité des communautés francophones. Elles se responsabilisent et s'approprient les soins de santé en français dans les communautés. Ces modèles doivent être encouragés en ce que la finalité...accomplit bien davantage que la simple livraison de services de santé en français... ».

Dans ce cadre, le gouvernement de l'Ontario a reconnu l'importance d'impliquer directement la population francophone au niveau de la planification des services de santé en français, comme vous le savez, en procédant à l'élaboration d'un règlement visant l'établissement d'entités de planification des services en français en Ontario. D'ici le mois de juillet, on devrait en avoir cinq qui vont voir le jour. Présentement, il y a des propositions qui se préparent à soumettre au gouvernement pour que des entités de planification des services de santé en

français soient établies. Elles travaillent conjointement avec les RLISS dans lesquels elles opèrent.

L'identification des besoins et la planification des modèles de livraison de services intégrés de soins de santé, de santé mentale et de lutte contre les dépendances en français de qualité vont faire partie du mandat des entités—de voir à ça : quels sont les besoins? Comment pourrait-on réintégrer? Qu'est-ce qu'on a suggéré comme modèle?—naturellement, à suggérer des recommandations aux RLISS.

De même, le RLISS du Nord-Est non seulement—maintenant, parce que ce n'était pas comme ça—reconnaît dans son plan de services intégrés de 2010 à 2013 le rôle essentiel de la langue et de la culture dans la prestation de services de santé, mais vise aussi à inclure l'intégration des services en français dans chacune de ses priorités. Les services en français n'est pas juste une priorité; les services en français est une priorité quand on regarde les besoins des personnes âgées, quand on regarde les services à offrir aux enfants. C'est une priorité à tous les niveaux. Il vise aussi l'inclusion d'une approche intégrée dans sa mission et sa vision. Quand on inclut les services en français dans une mission et dans une vision, comme vous le savez, ça découle dans des actes stratégiques par la suite, mais il faut faire un plan pour arriver à ça. Quand ce n'est pas là—jusqu'à maintenant, je pense que ça démontre un petit peu qu'on n'a quand même pas beaucoup de services qui sont accessibles en français de qualité dans le Nord-Est.

Alors, quand on regarde le pas que vient de faire le RLISS, puis le gouvernement, nous, on pense que ce sont des pas de géant qui vont nous aider à continuer à aller de l'avant dans l'établissement des services auxquels on peut avoir un meilleur accès.

Le temps passe, alors si vous permettez, je vais écourter.

Ça s'adresse à vous, membres du comité : une reconnaissance similaire du rôle essentiel de la langue et de la culture en matière de services en français, l'inclusion des services en français de façon intégrée dans chacune de vos sept orientations et au niveau de la mission et de la vision—je pense que, si vous faisiez ça dans votre dernière ébauche ou dans le dernier document à présenter au ministre, ça serait une bonne chose. Ça engagerait vraiment des actions concrètes par la suite pour s'assurer que ces services-là sont enfin accessibles.

Les pratiques exemplaires : comment peut-on faire pour améliorer? Là, je vais vous donner des suggestions. À titre d'exemple—on en parlait tantôt : si on prend les Services de Counselling de Hearst, Kapuskasing et Smooth Rock Falls, la seule organisation communautaire francophone dans la région du Nord-Est à offrir toute une gamme de services en santé mentale qui est accessible dans les deux langues officielles, on prend un exemple qui fonctionne. Cette organisation-là est multimandat, mais pour les fins de la présentation, on va se concentrer sur le côté santé mentale. Alors, elle offre une gamme de services de santé mentale. Quand je dis une gamme de services de santé mentale, on parle de services

d'évaluation, on parle de services de psychothérapie, on parle de services à la vie autonome—en anglais, on dit « case management »—on parle de services de diversion de cour, on parle de services psychogériatriques, et j'en passe. On parle aussi de services de cliniques psychiatriques en français que l'on offre dans la région. Je vais vous en donner un petit peu plus là-dessus tantôt.

Également, cette organisation-là est impliquée au niveau de la formation des professionnels de la santé et de la santé mentale. Comment c'est fait? En offrant des stages cliniques dans un environnement francophone aux étudiants de premier et deuxième cycles en travail social qui viennent faire des stages cliniques en milieu francophone. Il y a les infirmières, aussi, qui viennent faire des stages quand c'est le côté santé mentale. On a des étudiants d'écoles de médecine qui viennent faire des stages aussi, surtout lors des cliniques psychiatriques. On a eu, aussi, quelques résidents en psychiatrie de l'Université d'Ottawa qui sont venu faire des stages.

The Vice-Chair (Mrs. Christine Elliott): You have about five minutes left, monsieur Marcil.

M. André Marcil: Okay. On va passer. Disons qu'on avait un modèle ici.

Donc, il y a des partenariats qui ont été créés en cette organisation-là pour offrir des services de santé mentale, des consultations psychiatriques—donc des services de niveau 2—avec le programme de psychiatrie du nord de l'Ontario qui est offert par l'Université d'Ottawa, et aussi à travers l'Hôpital Montfort. L'Université d'Ottawa offre un programme, pas juste ici, mais partout dans le nord, des cliniques de consultation. Alors, elle fournit des psychiatres itinérants.

Ce que j'aurais à vous proposer : je pense que ce n'est pas raisonnable de penser qu'on peut avoir des services de façon parallèle à tous les niveaux. Si on pense aux services spécialisés, pourquoi ne bâtit-on pas sur ce qui existe en Ontario et qui est capable, par son excellence, de rayonner sur les autres organisations en Ontario qui offrent des services en français, et aller chercher ces expertises-là?

Je vous donne un exemple. Pourquoi ne mettrait-on pas en province un centre d'excellence provincial en santé mentale qui offrirait un accès à des programmes spécialisés en santé mentale à distance via télépsychiatrie? On pense tous à la question des gens qui sont pris avec des problèmes concurrents, alors les problèmes de santé mentale et de dépendance, ce qui est une expertise en soi. Ensuite, ce centre pourrait procéder à l'élaboration de programmes de prévention et d'éducation en santé mentale qui seraient accessibles. Pourquoi ne pas voir à ce qu'on ait un centre d'excellence où on va bâtir ce dont on a besoin comme programmes de prévention et d'éducation et ensuite les mettre à la disposition de tous les pourvoyeurs, les fournisseurs de services qui ont besoin d'offrir des services en français à leur clientèle?

Pourquoi ne donnerait-on pas aussi accès, à travers cette organisation-là, à de la formation professionnelle continue? Par exemple, sur le traitement de l'anorexie, le

personnel aimerait refaire un petit peu les connaissances, voir où on est rendu dans les traitements, quelles sont les mises à jour. À ce moment-là, le centre d'excellence pourrait permettre, à travers la vidéoconférence, d'avoir accès à plusieurs types de formation en français. Il pourrait aussi contribuer, aux niveaux collégial et universitaire, pour que des professionnels de la santé et formation puissent aller faire des stages. Il pourrait assumer un mandat d'expertise en évaluation. On parlait tantôt des programmes qui sont juste traduits, mais dont tout l'aspect psychométrique est laissé de côté. Puis aussi, il pourrait faire de la recherche; on parlait qu'il n'y avait pas de recherches, pas de données sur la santé des francophones en situation minoritaire. Il pourrait aussi offrir des programmes d'éducation et de formation aux fournisseurs de soins; on parlait des fournisseurs de soins qui sont une des portes. Quand on a des gens, des jeunes surtout, qui vont chez le médecin au niveau des soins primaires et qui présentent des signes précoces de problèmes de santé mentale, que ce soit psychose précoce ou autre, à ce moment-là on pourrait avoir un organisme qui pourrait donner cette éducation-là. Que ce soit par des modules développés—il y a toutes sortes de façons dont ça pourrait être fait.

J'aurais une autre suggestion. Je pense qu'on pourrait donner ce mandat-là à l'Hôpital Montfort. L'Hôpital Montfort est le seul hôpital universitaire francophone en Ontario qui a développé une expertise en santé mentale et qui dessert déjà—il nous donne accès, comme vous avez vu tantôt—pas un accès à 100 %, mais un certain accès au niveau de l'hospitalisation. Mais si on bonifierait le mandat de l'Hôpital Montfort pour leur permettre de développer cette expertise-là, tout le monde en Ontario fournissant des services en français pourrait en bénéficier.

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L'autre chose que j'aimerais vous proposer est au niveau de soins de santé secondaires, puis tertiaires, dans la région du Nord-Est. Là, on parle d'un rôle de Montfort, mais il ne pourrait pas jouer tous les rôles. Quand on parle d'avoir des services de deuxième ligne dans les départements de psychiatrie, il faudrait qu'on puisse avoir accès à des services en français.

Voici ce que je propose : on devrait développer une équipe multidisciplinaire francophone par département de psychiatrie, avec un superviseur francophone, pour s'assurer que la qualité linguistique et culturelle ne se perd pas, qui serait mandatée, en premier lieu, de desservir les clients francophones, et bien sûr, si le temps le permet, de desservir aussi les clients anglophones. Si vous faites ça dans chacun des hôpitaux, si vous recommandez que des équipes comme celles-là soient mises dans chacun des hôpitaux de district—il y en a six dans le Nord-Est—on pourrait faire la même chose avec la troisième ligne, qui est le Centre de santé mentale du Nord-Est, qui est l'hôpital psychiatrique.

J'ai parlé tantôt du fait qu'ils ont un programme de liaison communautaire; on travaille avec eux en partenariat. Celui-là, il répond aux besoins. Pourquoi ne

pourrait-on pas créer des équipes francophones multidisciplinaires à l'intérieur, où nos clients sont desservis, qui viseraient, avant tout, desservir les francophones?

On ne parle pas de modèle parallèle; on parle de mettre à l'intérieur des structures à gouvernance anglophone spécialisées—comme vous le savez, ce sont des soins spécialisés—des équipes qui pourraient répondre adéquatement à une clientèle francophone qui est quand même assez abondante dans le nord-est de l'Ontario. Je vous remercie.

The Chair (Mrs. Christine Elliott): Merci, monsieur Marcil. Thank you very much. We greatly appreciate your attendance before the committee today. Unfortunately, we don't have time for any questions, but I presume that any of the members of the committee can be in touch with you if they have any further questions?

M. André Marcil: Absolument. Vous êtes tous les bienvenus.

M^{ME} DIANE LAVALLÉE

The Chair (Mrs. Christine Elliott): Our next presenter is Ms. Diane Lavallée. Madame, do you wish to come forward?

M^{me} Diane Lavallée: Bonjour tout le monde. Good afternoon. Je suis vraiment très contente d'être ici, puis vraiment, je me trouve très privilégiée de pouvoir contribuer au travail très important que votre comité est en train de faire. J'ai eu la chance d'aller au sommet de la santé mentale en juillet dernier; je suis allée à la conférence « Making Gains »; et je suis très impliquée au niveau de l'est de l'Ontario, particulièrement du RLISS de Champlain, dans les activités.

Vous avez deux documents : vous avez mon texte complet, mais vous avez aussi ma présentation « PowerPoint ». Si jamais ça ne fonctionne pas, pas de problème; on va aller de l'avant quand même.

Vous allez retrouver dans ma présentation des éléments communs, des choses que vous avez entendues déjà, j'en suis sûre, des francophones qui vous ont fait des présentations, comme tout à l'heure, celle d'André Marcil. Je veux quand même vous raconter les histoires qui viennent de notre région, de l'est de l'Ontario.

Quand on dit l'accès aux services de santé mentale et de dépendances pour les francophones, ça veut dire quoi? Je vais vous raconter l'histoire de Jean-Guy. Jean-Guy est un jeune francophone de 22 ans. Il a besoin de services de santé mentale en français, mais il vit dans une petite ville principalement anglophone. On a bien essayé de lui trouver un service avec du personnel francophone. Il y avait une infirmière bilingue où il est allé, mais le psychiatre et le travailleur social ne le sont pas. Il est très frustré parce que le service ne fonctionne pas pour lui, et il se sent de pire en pire. Finalement, il décide de se rendre à Ottawa en autobus où il pense avoir plus de chance de se trouver un service en français, mais il n'a pas d'adresse locale, donc pas encore d'accès.

En santé mentale—on l'a entendu—un des outils clefs des soins et du traitement est la relation d'aide, la relation

entre l'intervenant et le client. Pour un francophone, la différence, c'est souvent de pouvoir s'exprimer profondément ou juste superficiellement, de comprendre correctement ou très peu, ou presque pas ou pas du tout. Donc, on sait que—vous l'avez déjà entendu—la langue et la culture de la relation du service ont un impact direct sur le résultat clinique pour le client et la population de tout le service de santé mentale et toxicomanie, comme nous l'appelons—ou dépendances.

L'accès aux services de santé mentale et de dépendances en français est crucial parce que, vous l'avez entendu, être francophone est un déterminant de la santé dans l'est de l'Ontario—on le sait—et ailleurs. Quand nous, Montfort, avons fait notre recherche sur les besoins de notre population, le consultant de Hay Group, qui a fait la recherche, a pu nous montrer que les zones francophones de la région de Champlain utilisent à 138 % les services psychiatriques, donc 38 % de plus que la population anglophone. L'information que notre RLISS de Champlain nous donne : les congés en santé mentale dans trois zones francophones de Champlain sont 6,3 sur 1 000, mais en Ontario, c'est 5,8 sur 1 000. Les congés liés à la dépression dans Champlain : c'est 1,3 versus 1,2. Ça fait une différence dans le nombre et dans l'intensité des besoins pour les francophones.

Les personnes âgées dans Champlain : 13,2 %, plus qu'en Ontario à 12,7 %. Mais dans Prescott-Russell, qui est à 80 % francophone, les personnes âgées sont à 14,9 %, et dans la petite ville d'Hawkesbury, c'est 21,3 %. C'est énorme, quand on pense aux problématiques de santé mentale et de dépendances qu'on voit et qu'on diagnostique maintenant chez les populations âgées.

Mais pour les personnes francophones avec des dépendances dans Champlain, on n'a pas d'informations précises. On sait que l'état de santé des francophones est déjà inférieur à celui des anglophones. Vous l'avez entendu; il y a des références, des rapports. Donc, pour avoir un impact positif sur la santé mentale de la population en général et sur l'économie de la santé au total, il faut adresser les problèmes de santé mentale des francophones et leurs déterminants. Il faut pouvoir mesurer et comprendre l'état de santé mentale et de dépendances des francophones de l'Ontario et pouvoir agir, parce qu'offrir un meilleur accès à des services de santé en français, c'est améliorer l'état de santé des francophones, mais aussi avoir un impact positif sur l'état de santé de tous les Ontariens. Et ça, en bout de la ligne, est critique pour vous, et c'est critique pour le gouvernement.

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Mais est-ce qu'on peut dire qu'il y a vraiment accès aux services de santé? Dans Champlain, 266 000 francophones en 2009—41 % des francophones de l'Ontario. Puis, quand on pense que 20 %—un sur cinq—des Canadiens vont avoir besoin de services de santé mentale dans leur vie, c'est plus de 53 000 francophones qui auront besoin de services de santé mentale et de toxicomanie. On a intérêt à bien faire quand ils se présentent chez nous pour que l'économie de ce service-là soit maximisée.

Mais dans Champlain—même dans Champlain—il est encore difficile de bien savoir combien de services ont une réelle capacité à offrir des services en français, bien qu'ils soient désignés. Vous avez entendu ce qu'André Marcil a dit. La désignation comme telle n'est pas un bon indicateur. On n'a pas de moyen de faire du suivi pour savoir si, effectivement, ces services-là sont disponibles. Je peux vous dire que sur 53 organismes dans Champlain qui offrent des services de santé mentale, il y en a juste cinq désignés et trois partiellement, et cinq autres devraient l'être. C'est bien peu : c'est huit services. En toxicomanie, désignés : trois; partiellement : aucun; devraient l'être : trois. C'est vraiment peu pour l'ensemble de la population.

On apprécie dans votre document que chaque porte est la bonne porte, mais pour un francophone, chaque porte n'est pas nécessairement la bonne porte. Plutôt, il faut que chaque porte mène à la bonne porte, et le plus rapidement possible.

Je vous conte une histoire : le « community resource centre » d'Orléans sait qu'une jeune fille se promène depuis plusieurs jours le long d'un boulevard à quatre voies. On a déjà appelé la police, qui dit connaître Isabelle, une jeune francophone qui vit seule dans un logement. Une intervenante anglophone qui parle un peu de français a essayé de l'approcher. Le 8 août, Isabelle marche en zigzag le long du boulevard. L'intervenante appelle la police, la rappelle; elle veut savoir si quelqu'un s'en occupe, et laisse un message au « constable ».

Le 9 août, la police rappelle en disant qu'Isabelle est bien connue de la police, mais à moins qu'elle ne mette sa vie en danger, ou celle des autres, il n'y a rien à faire. Rien d'autre ne peut être partagé; c'est confidentiel.

L'intervenante fait plusieurs appels pour enfin trouver la Ligne de crise en santé mentale, qui offre des services bilingues et qui va communiquer la situation d'Isabelle au « mobile crisis team » d'Ottawa, qui va essayer d'envoyer quelqu'un bilingue.

Le 10 août, Isabelle est à l'urgence de l'Hôpital d'Ottawa, où elle sera hospitalisée. Elle a tenté de se suicider en se jetant sur une voiture. Peut-être y aura-t-il quelqu'un qui pourra la rejoindre, en français, quelques fois.

Il faut donc des portes d'entrée claires, accueillantes pour les francophones; des corridors d'accès aux services francophones qui sont connus, compris et utilisés—c'est l'efficacité.

Ça prend un service d'aiguillage pour francophones pour diriger les personnes et leurs proches vers les services de santé mentale en français; partager l'information requise, faciliter les références et assurer un suivi jusqu'à la bonne porte. C'est utile pour les organismes anglophones qui essaient d'offrir un service bilingue mais qui ne peuvent pas. Ce service d'aiguillage-là est déjà un modèle qui a montré son efficacité dans d'autres régions, comme le Québec.

Ça prend une masse critique de services et de ressources francophones de santé mentale et de dépendances, qui peuvent être liés entre eux de façon virtuelle et réelle en

un centre d'excellence francophone, qui ensemble peuvent :

- assurer un continuum de services de santé mentale et de dépendances coordonné et intégré, avec leurs partenaires de services anglophones du RLISS;

- développer les connaissances et l'expertise nécessaires pour offrir des services de qualité en français, et partager ces meilleures pratiques-là en services francophones avec les autres RLISS de l'Ontario;

- soutenir les RLISS et les organismes désignés de l'Ontario, ou les autres qui ont des francophones qui se présentent à leurs portes, pour qu'ils puissent offrir des services de santé mentale et de dépendances primaires et secondaires efficaces et efficients à leur population francophone;

- offrir à distance, via la Télésanté—aujourd'hui, il n'y a pas de raison de ne pas le faire—des services de santé mentale et de dépendances secondaires et spécialisés tertiaires en français, par exemple, en troubles concomitants—une expertise que nous avons déjà développée;

- participer à la formation et au soutien des professionnels offrant des services de santé mentale en français partout. Il y a beaucoup d'anglophones—les jeunes anglophones, vos enfants qui sont allés en immersion—qui sont des francophones qui s'ignorent, qui ont beaucoup plus de capacités qu'on ne le sait—un coup bien nourri et bien soutenu. Il y a beaucoup d'anglophones en Ontario qui ont des connaissances en français et qu'on peut mettre à profit, qui vont être fiers, eux aussi, de pouvoir collaborer et participer à l'offre de services en français. Pour ça, il faut les soutenir;

- assurer un mandat universitaire de formation de professionnels de santé francophones, mais de formation continue à tous les professionnels qui ont une capacité en français pour qu'ils puissent bien offrir. Ce n'est pas réinventer la roue, mais rendre le système efficace et efficient;

- assumer un mandat universitaire d'évaluation de programmes, de recherche en santé des populations francophones en situation minoritaire. On a l'Institut francophone de recherche interdisciplinaire en santé à Montfort. C'est un petit bourgeois qui cherche juste à pouvoir éclore, puis participer justement. On a déjà commencé des recherches. On a la capacité; on a le vouloir.

Un centre d'excellence francophone en Ontario, c'est la capacité de devenir un modèle de services adaptés à toutes les autres minorités linguistiques. Quand on est capable de bien le faire en français, on est capable de savoir comment le faire pour toutes les autres minorités linguistiques, tous les autres qui arrivent à nos portes, qui sont là et qui ont besoin de services aussi dans des régions comme Toronto. C'est la capacité de devenir une fierté et une force dans notre système de santé ontarien et canadien.

Pour diminuer le poids de la maladie mentale et des dépendances—c'est un aspect critique—il faut promouvoir la bonne santé mentale de tout le monde, mais des francophones en particulier, et miser sur la pré-

vention. Vous l'avez bien identifié dans votre document. C'est difficile pour les jeunes, pour créer la psychiatrie de demain.

Une autre histoire vraie : madame Dagenais appelle un service pour de l'aide pour son fils de 18 ans qui est dit « délinquant ». Il consomme des drogues, de l'alcool. Il a des comportements imprévisibles, des colères. Il a arrêté l'école. Il fait du vol à l'étalage pour se procurer de la drogue—on entend souvent cette histoire-là. La mère décrit des symptômes psychotiques, mais son fils nie qu'il a des problèmes de santé, encore moins des problèmes de santé mentale. Il refuse toute aide. Madame Dagenais a peur pour son fils et pour sa famille. Elle cherche du soutien, en français, s'il vous plaît, si c'est possible.

Promouvoir une bonne santé mentale de toute la population, y inclus les francophones, veut dire :

- rejoindre les francophones dans leur vécu, dans ce qu'ils sont, dans leurs communautés, dans ce qui les a marqué, ce qui les marque encore;

- déstigmatiser : c'est vrai, la Commission de la santé mentale du Canada, dans votre initiative—déstigmatiser, normaliser le fait de s'occuper de sa santé mentale autant que de sa santé physique avec des campagnes de promotion de stratégies de prévention culturellement francophones dans le contexte ontarien;

- comprendre l'impact des déterminants de la santé mentale et des dépendances sur les francophones en situation minoritaire : des communautés appauvries, des communautés industrielles, des communautés où il y eu un vécu religieux institutionnel qui a mené à des abus comme dans d'autres communautés. C'est encore vrai en communauté minoritaire francophone;

- dépister les besoins et les problématiques au plus tôt en tenant compte des facteurs de risque propres aux francophones et aux communautés dans lesquelles ils vivent. Ça veut dire créer des façons de répondre aux besoins des francophones avec une efficacité démontrée. C'est ça qui va être gagnant; c'est ça qui va être payant pour le système.

1740

Pour que ce soit gagnant et payant pour tous, il faut bâtir sur ce que nous avons déjà et oser aller plus loin. Assurer l'accès à des services francophones de santé mentale et de dépendances basés sur les meilleures pratiques et les données probantes est :

- reconnaître notre capacité, nos organisations, nos partenariats déjà, les organisations francophones en santé mentale et en dépendances;

- soutenir la coordination, l'intégration et le développement de nos services pour la santé des francophones de l'Ontario et de tous les Ontariens;

- financer nos services cliniques, nos projets créatifs et prometteurs, la formation de nos professionnels, la recherche en santé mentale et en dépendances des francophones en situation minoritaire.

On a parlé de soutenir la validation formelle des outils d'évaluation cliniques et de collecte de données du ministère, comme le prochain OCAN. André en a parlé. Des traductions maison, c'est dangereux. On va s'en servir

pour toutes sortes de choses et pour du financement dans le futur. Ça prend des outils validés. On a déjà la capacité de faire les études de validation nécessaires; on en fait déjà à Montfort. On peut assurer la qualité égale de ces outils-là pour des résultats de qualité égale. C'est ne un risque que personne veut prendre. On peut s'en passer.

Une histoire pour vous raconter ce c'est possible : madame Lafrenière a 50 ans. Elle est d'une petite communauté du nord de l'Ontario. Elle s'est rendue à l'urgence de l'Hôpital Montfort pour recevoir des services en français parce qu'elle a un problème de dépendance aux médicaments antidouleur et a des symptômes d'anxiété sévères. Elle n'en peut plus; son mari et ses trois adolescents non plus. Tout s'écroule autour d'elle et dans sa famille aussi.

L'urgentologue demande une consultation à notre psychiatre spécialisé en troubles concomitants, santé mentale et toxicomanie, qui décide de l'admettre pour une évaluation interdisciplinaire de son fonctionnement psychique et une révision de ses médicaments. C'est là qu'elle partage, pour la première fois de sa vie, son vécu d'abus sexuels durant l'enfance, qui impacte sur son fonctionnement actuel. Après 14 jours d'hospitalisation, le portrait est maintenant clair et le traitement approprié aussi. Mais les services spécialisés en troubles concomitants en français, disponibles à l'externe de Montfort, n'existent pas dans sa communauté, même pas dans le Nord.

On lui propose quand même un groupe intensif à notre hôpital de jour, mais il lui faudra de l'hébergement temporaire parce que sa famille n'a même pas les moyens pour un motel. Notre équipe contacte donc un de nos partenaires qui opère une résidence pour personnes âgées avec des problèmes de santé mentale, et on accepte de faire une entente spéciale pour que madame puisse rester là pour huit semaines pour participer à notre programme AGIR de huit semaines à Montfort.

Madame n'a jamais pris l'autobus, n'a jamais même été dans une grande ville comme Ottawa, mais avec le soutien de toute l'équipe chez nous, à la résidence, elle se débrouille très bien. Après huit semaines, elle fonctionne déjà beaucoup mieux. Elle a réussi à arrêter sa consommation problématique grâce à une médication beaucoup plus appropriée et à la psychothérapie individuelle qui l'aide à ne plus avoir mal physiquement et moins mal émotionnellement. Elle développe une meilleure estime d'elle-même, et son anxiété est significativement diminuée. Elle a des meilleurs contacts avec son mari et sa famille au téléphone, et son retour chez elle se passe bien.

Un mois plus tard, M^{me} Lafrenière téléphone au psychologue des troubles concomitants pour remercier l'équipe et confirmer que ses acquis se maintiennent. Elle a retrouvé une certaine joie de vivre avec son mari et ses enfants qui, eux aussi, sont moins stressés. Oui, ces services ont eu des résultats positifs pour elle, pour sa famille, pour ses enfants et pour la communauté.

Des services de santé mentale de qualité en français est un droit. Vous l'avez déjà entendu; ce n'est pas une surprise. Ce que je pourrais ajouter, c'est que dans le

jugement Montfort, on nous a donné le mandat de maintenir et de transmettre la langue française, de favoriser la solidarité parmi la communauté franco-ontarienne et ainsi, de prévenir toute forme d'assimilation. C'est vraiment un mandat qu'on prend à cœur, et on a le goût et le désir—tous les partenaires ensemble autour de Montfort—de pouvoir faire rayonner ce qu'on a à travers Champlain, puis à travers la province. On est voulant, on est participant, on est capable, et on a vraiment le sentiment qu'on peut et qu'on va faire une différence en faisant ça.

On parle du 25 septembre comme jour proposé des Franco-Ontariens et des Franco-Ontariennes, qui soulignera le 400^e anniversaire de la présence française en Ontario. Est-ce que c'est vrai qu'on va avoir le droit d'exister, de la valeur pour tout le monde autour de nous, qu'on peut espérer? C'est avec des communautés fortes, fières et optimistes qu'on peut réaliser une bonne santé mentale pour toute la population. Merci beaucoup. J'aimerais bien répondre à vos questions.

The Vice-Chair (Mrs. Christine Elliott): Thank you very much for your presentation. We'll start with the government side. Do you have any questions you would like to ask Madame Lavallée?

M^{me} Diane Lavallée: And I'll be pleased to respond in English.

The Vice-Chair (Mrs. Christine Elliott): Thank you, Mr. Leal.

Mr. Jeff Leal: Merci beaucoup. It was excellent. It's really a pleasure for us for you to be here. I know my colleague Jean-Marc Lalonde from Glengarry-Prescott-Russell is always singing the praises of the great work that is done at the Montfort Hospital and your community outreach.

Just a question about the LHINs in terms of their planning: How do you see that role evolving into the future in terms of providing mental health service and overall planning, particularly for the francophone community?

M^{me} Diane Lavallée: I was really pleased to see the last presentation from the LHINs in terms of the integration of health services within Champlain—the vertical integration, the horizontal integration and the development of regional programs. Regional programs in mental health and addictions are certainly in the books, as is a cancer hub, as is maternal newborn care.

Absolutely we feel—and I must say that the francophone partners are all together at the same table at the Addictions and Mental Health Network of Champlain. I'm the chair of the scheduled mental health inter-hospital committee, where all the hospitals sit. I happened to be the chair over the last year and this year, and we're all on the same page of moving mental health and addiction services forward. We're doing together an integrated bed management process.

Where the francophone piece comes in is with the respect that in fact, yes, that is a piece, a significant piece. It needs to be well addressed in the context of the whole of the LHIN's planning, and with the francophone planning entity that will be designated very soon. For

now, we're working with the réseau des services de santé en français. It's one of the francophone networks that was created years and years ago that is very effective and very active in Champlain, and that has a direct link and in fact a partnership agreement with the LHINs in Champlain. There is a table of all the French partners in health and social services for mental health, addictions and developmental disorders.

So the linkages are already there. They're already very effective. We can see that with the proper ability to plan on the francophone side, with a very strong partnership agreement and link of the planning entity, the réseau planning entity, with the LHINs, with the concept of the horizontal and vertical integration needed for the whole of the mental health system, we can create something quite forward-moving in Champlain.

Mr. Jeff Leal: So you're seeing that the LHIN structure in your area has been quite effective, then.

M^{me} Diane Lavallée: Not yet, no.

Mr. Jeff Leal: But moving towards that point.

M^{me} Diane Lavallée: Moving towards a program that will be Champlain-wide, where there will be a very clear, respected, understood, used, and maximized francophone component of that, where the francophone services can be used to the maximum to provide services for the francophone population, that the other pieces of the structure can also do their part to the maximum of their ability and that we can stream the francophone population to the best service at the best time in the best mode of offer, which may be, for a large part of them, in French, en français, dans un milieu francophone.

1750

Mr. Jeff Leal: Good. Thank you very much.

Ms. Sylvia Jones: Thank you for your presentation. I wanted to ask you a little more detail about your first story: Jean-Guy. You mentioned that because he didn't have a local address he did not have access to service. You can't be referencing the actual hospital visit; I'm assuming it is related to outpatient. Can you explain—

M^{me} Diane Lavallée: Yes, I can tell you the other part of the story. These stories come from a very fledgling service that has been financed with project funding only and is always trying to get more stable funding. It's called le Guichet—and you see that at the end—le Guichet pour francophones.

In fact, what happened, this young man was from Cornwall, and tried and tried. Finally he took the bus, came to Ottawa, showed up in emergency, didn't need to be admitted, was returned out, went back and tried to access an intensive case management service that he had accessed before, Horizons Renaissance, but since he was no longer a resident in Ottawa—he was in Cornwall—they couldn't provide service.

Through the people at Horizons Renaissance, they said, "Well, yes, we've got an issue here." They phoned their partner, Jeanne Hélène at le Guichet, Montfort Renaissance—that's the group that operates a residence for seniors and people with mental health issues—and they made a deal. They said, "Okay, we'll try to find him

temporary lodging with an address in Ottawa so that he can go back on your caseload and he can be properly followed by your case management service and access the psychiatric services that he needs," and, in fact, that's what happened. But until that connection was made and the discussion between partners to see what could be done, he would have probably been on the streets, probably back to emergency, probably get discouraged, go back to Cornwall and just float around in the system until his schizophrenia became really well-entrenched.

So through a network of services that know each other, that have corridors of access, that have ways to create a multi-organizational plan around a client—that's what we're already doing. That's where the future is and that's where not only one organization can meet the multiple needs of a client with mental health and addiction issues, but probably a collection of organizations around a client can do that. When it's a well-coordinated and integrated system, then it's a lot easier to do so. Right now, it's dependent on the fact that all of us working in French around Ottawa—and because through Montfort we have very strong partnerships, we have our primary partners—we know each other, we're around the table and it happens.

Ms. Sylvia Jones: The partnerships are obviously a huge assistance to people like Jean-Guy, but ultimately it is funded centrally through the Ministry of Health. So we have to eliminate those artificial boundaries of, "We won't serve you because you're from a different LHIN."

M^{me} Diane Lavallée: Totally, and we have the opportunity to go to other consultation tables for the strategy. Right now, the way that the services, particularly community and mental health and addictions services, are financed, at this point that type of financing has served its useful course. At first, it was very important for those other vote services to be structured the way they were, to be financed and protected the way they were to ensure that crisis services would receive crisis service money, and that's what they would do and nobody else could pull from their pot. The challenge is, now we're at a stage where we've got artificial barriers between services, and at Montfort, my mental health program has a continuum of services. I have six mental health services, I have a large in-patient unit and growing, and I have ambulatory care services.

Hospital and ambulatory hospital global funding: My six community services all underwrote funding. However, all have admission criteria, all have CDS reporting requirements, all have "Thou shall do this, but thou shall not do that," that, at this point, 10 years later, has served its usefulness. It's time to change that model to protect community mental health and addictions funding, absolutely, but to be able to enable a lot more flow of clients.

Also, we've done creative things. They're all Montfort clients, so we've got our ACT clients who get their off hours' on-call service by our crisis service and come to Montfort, are admitted to our unit, go to our day hospital, go back to the ACT team. What I'm wishing for is one

electronic record. I'm looking forward to that integrated assessment record where the community OCAN assessment and the in-patient RAI assessment can be seen by all, and there are lots of good things happening. We're ready to move in that direction. We have to have them in French. We have to have them validated, but we're already doing e-validation studies for a formal tool in Champlain, and we're looking forward to doing the rest.

The Vice-Chair (Mrs. Christine Elliott): I believe, Ms. Sandals, you also had a question.

Mrs. Liz Sandals: Yes. Following on with this discussion you've just been having, this has triggered a question for me, and it's not just a francophone question, it's an anglophone question as well. When we think about physical health services, we do things like keeping MRI lists and encouraging people, if there's a big wait list in your area, to go someplace else where the wait list is shorter. I come from Guelph, which means that doctors have ties in London and Hamilton and Toronto, so people go off in three different directions if they need tertiary care and nobody seems to get super hung up about LHIN boundaries, at least for tertiary services.

Then we come to mental health, and I happen to have a psychiatric hospital in Guelph. There's a constant struggle around psychiatric beds. They're usually occupied by people who aren't from Guelph and people say, "Oh, but these beds are open to everybody all over the province." Then you go to some other service, and somebody will say, "Oh, but you can't have that residential service because you're from Guelph." Then we go to when we were in southwestern Ontario, we heard about one little pocket in southwestern Ontario where people were told, "You can't go anywhere if you need that service; nobody covers you." Now I hear the same thing, like, "You're from Cornwall; you can't access the service"—the same thing on the francophone side.

So where do these rules come from about all the agencies that say, "No, you can't access my service"? Because it seems to be a humungous issue in the whole mental health system that there are these very well-defined boundaries about, "Oh no, you can't go there."

M^{me} Diane Lavallée: Maybe it's because it has been so hard to make due with the little there was, and the huge, huge and increasing demand and the ability to only scratch the tip of that iceberg with the sickest and the most needy, dangerous—whatever—clients, that there is a very natural protection instinct that's there, because there has been little. Also, the mindset is one that exists still. The advent of the LHINs, the advent of regional programs and the advent of this, I think we're just starting to see it, really, becoming more concrete. It's a lot easier in physical health, but that mindset needs to be facilitated, supported and nourished. Creative projects need to get kick-start funding. Things that will rally people around the needs of the client and what are good options and opportunities to go forward versus the provider organizations' instinct of protection around what they may have and can't possibly share with anybody because they'll be stuck and nobody—

Mrs. Liz Sandals: What that creates is a huge problem for people outside all but the largest communities, because there tend to be more services in the larger communities. If you have people putting silos around the—albeit limited—services that exist, you then end up with people in smaller communities constantly being told, “You can’t come here because you’re not from here.” Where do people feel they get the authority to say that?

1800

M^{me} Diane Lavallée: Well, the community engagement activities of the LHINs need to be able to bring that voice out, but we’re still faced with the stigma of mental health.

Mrs. Liz Sandals: But this is something that doesn’t seem to be connected to the LHINs at all, this silo of “You can’t be here.” This is one thing I honestly don’t think is a—

M^{me} Diane Lavallée: Are those provincial organizations, or are they all now under the LHINs?

Mrs. Liz Sandals: In many cases, they are probably organizations that aren’t controlled by the LHINs.

M^{me} Diane Lavallée: Exactly. They’ve been operating on their very own. They’ve been their own boss. They’re reporting to whom? Well, maybe directly to the ministry, but now that’s less than clear. So they are the king of their castles, and they’ve been operating that way for years and years and years.

Mrs. Liz Sandals: Yes. I think this is it. Somewhere they’ve gotten this attitude that long predates the LHINs.

M^{me} Diane Lavallée: Yes, absolutely. If there’s no clear link for them into the local health system, then it’s pretty easy to just stay apart. In eastern Ontario and probably the north, I don’t think—we, personally, don’t have that. Our tertiary hospital, the ROH, is part of our LHINs and is part of our scheduled mental health inter-hospital committee. We talk about issues of secondary care, access to tertiary care, the blocks that are there and the reasons for that to happen. There’s a lot to be done so the system can roll as a well-oiled machine. Mental health is very worthwhile. The nail was hit on the head. It’s a huge issue. It’s very costly. It’s a tragedy.

We all know, we all have in our families, people who did not achieve their potential, to the detriment of themselves, their family and their community. In fact, today, if there’s a key piece that we can all do, it is work on that normalizing. I think one of the key things that is new in this strategy is the recognition that clients, people with lived experience, have significant knowledge, inside knowledge, that providers don’t have and that they, then, need to be an integral part and partner in all aspects of this service.

For the francophones, well then, it means that francophone clients have to be able to relate with not only their own providers but also, at a certain level, with the

management, the administration and the planning of the services. That’s a very important piece.

In Champlain, our new Addictions and Mental Health Network of Champlain was just recently pulled together. Our LHINs really wanted to see that. We wanted to see that. It’s a for-for-for-for partnership: for mental health providers, for addictions providers, for clients and for family members. That’s the model. We will go through growing pains, but we will do that. We have francophone and anglophone representation, we have aboriginal representation, and we have subcommittees and work groups.

On the francophone side, we’re going to get around that table and see how we can contribute to the whole, what we need to bring to the whole, what we need, together, to make sure happens so that across the board, the population of Champlain—because that’s what it’s all about, the population of Champlain—will end up with a better status of mental health and addictions.

The Vice-Chair (Mrs. Christine Elliott): Thank you very much, Madame Lavallée, for appearing before the committee today and for sharing your insights into these issues with us. We’re looking for solutions, so we appreciate very much your attendance here.

M^{me} Diane Lavallée: It’s been a real pleasure. Good luck in your deliberations. It’s very important work. We’re very pleased to see you doing this.

The Vice-Chair (Mrs. Christine Elliott): Thank you very much.

If I could ask the members of the committee to stay for just a few minutes, we have a couple of housekeeping issues that I think we need to deal with, but they shouldn’t take very long, just two items Susan asked me to bring to your attention.

One is just a reminder that on Monday we are going to be meeting in committee room 2 at 6 o’clock for our evening session. I think everybody probably already has it in their calendar, so this is just a reminder.

The other item is a motion with respect to approval for some expenses. I’ll just wait for a moment to deal with that.

Ms. Sylvia Jones: Committee room 2, you said?

The Vice-Chair (Mrs. Christine Elliott): Yes.

I believe there was previously a motion before the committee to approve the expenses for all three of the presenters who appeared today. At one point Mr. Marcil said that he was going to appear by teleconference, so we didn’t specifically approve his, for that reason. But then he did appear today, so we just need a motion to approve his expenses.

Mr. Jeff Leal: So moved.

The Vice-Chair (Mrs. Christine Elliott): Moved by Mr. Leal. All in favour? Carried. Very good. Thank you.

All right, that’s the conclusion of our business for today. Thank you very much for bearing with me.

The committee adjourned at 1807.

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Mr. Jeff Leal (Peterborough L)

Mrs. Liz Sandals (Guelph L)

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Journal des débats (Hansard)

Mercredi 21 avril 2010

Select Committee on Mental Health and Addictions

**Mental health
and addictions strategy**

Comité spécial de la santé mentale et des dépendances

**Stratégie sur la santé mentale
et les dépendances**



Chair: Kevin Daniel Flynn
Clerk: Susan Sourial

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LEGISLATIVE ASSEMBLY OF ONTARIO

SELECT COMMITTEE ON
MENTAL HEALTH AND ADDICTIONS

Wednesday 21 April 2010

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ SPÉCIAL DE LA SANTÉ
MENTALE ET DES DÉPENDANCES

Mercredi 21 avril 2010

*The committee met at 1548 in committee room 1.*MENTAL HEALTH
AND ADDICTIONS STRATEGY

JOHN HOWARD SOCIETY OF ONTARIO

The Chair (Mr. Kevin Daniel Flynn): I believe we have a quorum of members, so we're going to get started. My apologies to our guests. You kind of hit the perfect storm today as far as the legislative agenda's concerned. Some of us were up there trying to read petitions, and we had some ministerial statements. We had a tribute to a previous minister and member, so some of the members will be joining us in progress. But in the interests of not inconveniencing you anymore, if you'd like to come forward and begin your presentation, that would be great. Sit anywhere you're comfortable.

Is the slideshow yours, or is that for the next presentation?

Mr. Bruce Simpson: No, not us.

The Chair (Mr. Kevin Daniel Flynn): Okay. We originally had you scheduled till 4:15, so about a 45-minute presentation. Were you going to leave any time for questions?

Mr. Bruce Simpson: Yes, I think so. In fact, I think in many respects it's easier to make a presentation with questions. I like questions myself.

The Chair (Mr. Kevin Daniel Flynn): Oh, do you? Okay. Well, why don't you kick it off and make some opening statements, and then we'll turn it over to the committee members. I'm sure we'll have a great discussion. Thank you very much for being here, and thanks for your patience. And I need you to introduce yourself for Hansard when you speak.

Ms. Paula Osmok: Thank you. I'll start. I want to say, first of all, how pleased we are to be invited today to speak. As you know from the materials that we've directed to this committee and to others, we've been concerned about community criminal justice organizations not being included in this and other consultations on the issue and feel that our input is valuable. The intersection between mental health and criminal justice involvement is important and challenging.

Our presentation today, as you can see, is being given by three representatives of the John Howard Society: myself, Paula Osmok, the executive director of the John Howard Society of Ontario; to my right is Liisa Leskow-

ski, executive director of the John Howard Society of Thunder Bay, who will bring some more local issues on the ground to you; and to my far right is Bruce Simpson, lawyer and senior partner at Barnes Sammon in Ottawa, who is also a long-serving president of our board of directors at the John Howard Society of Ontario.

For those who don't have a lot of knowledge about the John Howard Society, it's a criminal justice sector social service agency with charitable status that's working to achieve fundamental and long-term changes in individual behaviour, public attitudes towards crime and criminal justice, and government policies that are not grounded in the literature.

The society has a rich history of providing effective, evidence-led programs and services to a variety of groups: those at risk of becoming involved in the criminal justice system, those who are involved in the system, incarcerated individuals, and those who are re-entering our communities on release from prison.

The John Howard Society was established in 1929 by the then chief of police, Brigadier General Draper, who, through his work on the police force here in the city, recognized that men returning from local prisons were very quickly re-establishing their criminal behaviours and, without supports, were quickly returning to prison. He organized a group of citizen volunteers to meet with the men immediately on their release and provided them with support to address their basic reintegration needs, which include things like housing, employment, addiction issues, things that we now refer to as criminogenic factors.

General Draper's belief, which is strongly supported by research today, is that an essential component of community safety lies in social measures that support the re-entry of those who've offended into our communities as law-abiding and contributing citizens.

Currently, in 2010, the John Howard Society across Ontario consists of our provincial office, with the primary responsibility of research and policy, program evaluation, public education, fund development and some administrative matters, such as our benefit and pension plans across the province. We have 19 regional affiliates and a number of sub-offices from those affiliates who are responsible for all of the direct services to members of our community. They include a wide range of early and primary prevention programs, such as parenting and life skills; early intervention programs, including things like

alternatives to suspension; individual group counselling; specialized employment and literacy programs; institutional services, including pre-release planning; as well as re-entry services and supports, which I talked about a little bit earlier.

Interestingly, our newest affiliate, the John Howard Society of York Region, just became operational this year. I know one of your committee members represents that area.

We have over 600 professional staff and almost 1,100 trained and supervised volunteers who are involved in delivering programs and services to our often high-risk and high-need populations.

As you know, the rates of mental health concerns and addiction within prison populations are disproportionately high, and I'd like to just share a few stats that you may already be aware of.

A study was done in Ontario by Dr. Gregory Brown at Nipissing University, and I know that's a name you're familiar with. Just, interestingly, a few of them: 5% of inmates demonstrate a high number of severe symptoms of mental illness; 35% have a moderate number of severe symptoms of mental illness; 61% of men incarcerated have addictive behaviours; 91% of women incarcerated have addictive behaviours; there is no effective support system in place for 62% of the men leaving prison; substance abuse by those incarcerated is eight times more likely to occur than in the general population; a history of physical, emotional, sexual and family abuse is substantially higher among inmates than in the general population; and the ability to function in society for those leaving incarceration is 72% of that of the general population—certainly some stats that are concerning.

While the correctional system makes every effort to identify and treat these concerns, they do persist, and they're often exacerbated by the nature of the institutions themselves.

The relationship between addictions and mental health concerns and the likelihood of re-offending is similarly clear. Without meaningful and ongoing treatment, these factors quickly land releasees back in prison. The interventions and supports provided by the John Howard Society across Ontario break or slow the cycle of incarceration for many of these releasees who have treatment and other service needs.

Comprehensive assessment and treatment of addiction is crucial to the success of reintegration after incarceration. Addiction to illegal drugs and drug-seeking behaviour is a significant factor both for arrest and incarceration, and holding cells in detention centres often find themselves playing the role of a detox centre for addicts who are struggling.

Whether they've been using during their incarceration or undertaking treatment programming, experience with prisoners clearly shows us that many revert to drug taking after release from prison. This behaviour puts releasees at physical risk, dramatically increases their chances of re-offending or breaching, and also significantly increases the chance that any aspects of discharge

planning that they've been engaged with while they have been in prison are not likely to be successful.

In addition, experts tell us that an estimated 30% to 50%, or even higher rates, of prisoners have fetal alcohol syndrome disorder, adding another level of need to this population. And we all know that the risk of suicide is much higher with men who are incarcerated, particularly those who are in remand populations.

In a similar fashion, those with significant mental health concerns often engage in a cycle of incarceration and crisis in the community without comprehensive and preventive treatment in place. While good treatment settings do exist within the provincial correctional setting for sentenced prisoners—and I add "sentenced." As you may know, the bulk of our population in provincial institutions right now are on remand; they are not a sentenced population. Those institutions are two in number: St. Lawrence Valley and OCI in Brampton. This treatment, as that points out, is not available to all, including, as I mentioned, remand. Those who show less severe symptoms or who have personality disorders often leave the system without any meaningful assessment and certainly without treatment.

Without reintegration services, those with persistent mental health concerns face fairly gloomy prospects. The transition back into the community can be isolating and jarring, and the search for a treatment provider can be confusing. The lack of resilience and initiative that's so commonly associated with mental health concerns can certainly be a significant barrier to the networks of support that we have in place. When behaviour that has often led to incarceration isn't adequately managed in the community, the road back to prison is the one they likely follow.

The answer to this cycle of abuse and mental health crises lies in meaningful and comprehensive treatment and supportive programming before and after release—again, much of which is already provided by the John Howard Society, and numbers certainly warrant additional programs of this nature.

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You may not be aware that the Ministry of Community Safety and Correctional Services is responsible for health care while people are in prison. It isn't the Ministry of Health, interestingly.

Finally, if our goals include good health and community safety, then we do need comprehensive and quality assessments and comprehensive and quality services by professionals and agencies such as the John Howard Society, that understand that the intersection between mental health and addiction concerns and the criminal justice system is significant.

I'm going to ask Liisa to carry on.

Ms. Liisa Leskowski: I apologize. I am the offender who left her phone on that was going off. Although we do respect Paula as the leader of Ontario, music doesn't always play when she talks.

I presented to you when you came to Thunder Bay. I understand you want to hear about prisons.

We are a community justice organization that works outside of prisons—and I personally have a background. I've worked as a chaplain inside the district jail in Thunder Bay and inside the correctional centre in Thunder Bay. I've worked as a reintegration community worker, helping individuals reintegrate back into the community. And for the last four years, I've been the executive director of the John Howard Society. So I've worked both inside and out.

Once a person with a mental illness enters the system, whether that's incarceration in a police lock-up, in a remand centre or a correctional centre, in a provincial or federal facility, it's sadly too late. I think we've failed. As a society I think we've failed, and I think as systems we've failed if someone with a mental illness ends up incarcerated. These are my opinions.

I personally believe that prevention and treatment largely become maintenance of mental health symptoms. Incarceration becomes kind of the accelerant for the disease symptoms.

Prisons are the means of punishment. That fact alone will always trump services that are delivered inside. I know there are a lot of good people involved in MCSCS and the services they provide, who really try to ensure things like psychiatrists' visits once a month, that there are medications, that a person can carry on. However, if that medication is a narcotic, you won't get it because it'll be seen as a controlled substance, and the inmate will go without that. I've seen that happen. There's obviously no cognitive therapy that's going on or supportive mental health programming. Any drug therapy, from what I've seen, will be minimal and maintenance at best, especially if it's a remand centre or a district jail.

The key has to lie in a really strong strategy for diversion of mental health consumers, where possible, from traditional justice services. That's seen as the goal, I think, by most justice sectors and health sectors. However, from my perspective as a community service provider, there has been little or no integration of the new health funding that has been put out over the last 10 years with what has been community-based justice funding.

The bail programs are a perfect example of this. Low-risk individuals are released into community-based service providers, into bail programs, and they are able to supervise and support these individuals in the community. We can support someone for a few weeks to up to a year.

Here are the stats of who is in my bail program. I'm giving you the stats from Thunder Bay's bail program. We support about 250 individuals: 50% struggle with a current or alcohol addiction; 70% have a history of substance abuse; 25% have a diagnosed mental illness, and it goes to more than 50% if it's undiagnosed; 10% have acquired brain injuries; 90% are male, and over 50% are aboriginal.

This is a diversion program that receives no support from mental health services. Bail programs provide supervision of court orders for our clients. Through that, we're able to develop trusting relationships and help that

individual in their journey away from conflict with the law. We are funded to address the criminal behaviours, but we often find ourselves scrambling to deliver the human and social services which address the underlying causes, sometimes, of a person's involvement with the law.

When an individual is picked up, they're held overnight. They make their first appearance the next morning, and decisions are made then about whether they can be released on bail or if they'll end up staying in on remand or staying in jail for a little longer—and then, if they do, they'll be sentenced and consequently incarcerated. It would make sense at this intersection to ensure that as many individuals with mental health issues as possible are diverted. However, the need to move people quickly through that process, through the court system, is really challenging. So, when a person ends up that night in jail, the next morning there could be 30 people on a court docket that the crowns and the JPs and the defence bar are trying to push through very quickly. It's virtually impossible to do any sort of assessment at that intersection, at that front end. But there really do need to be supportive mental health services at that end, and those should include not only assessment and referral but support workers to help individuals with mental illness that find themselves getting caught up in our legal system.

The justice system is seen by the health system, including the mental health system, as unresponsive to the diverse needs of the mental health consumer. Health-funded organizations have largely been advocating for pathways to be developed through health and not justice. However, those of us who work with the mentally ill or the addicted offender often, at that intersection of justice and health—namely, community criminal justice organizations—are funded by justice and we feel that we have not been unresponsive to the mental health needs. And if the justice system doesn't get funded as well as the health system, then those of us who deliver services at that end won't receive the resources that are needed to help these clients. As partners with justice in delivering community-based programs and services, our unique position allows us to provide many of the local supports required by mental health consumers. Yet our services have largely been overlooked not only by the health sector but also by the justice sector that funds us. As a result we have seen client caseloads rise, we have seen our budgets cut and we've seen ourselves continually servicing higher-needs mental health clients.

I think there really needs to be a partnership between justice and health, and resources put to a real solid look that is done to say, what are we delivering now that's effective in diverting individuals away from the criminal justice system, and how can we help that? I would strongly advocate for resources to be allocated and used that expand existing community justice services as well as health services. I think the goal needs to be keeping people out of our prison systems. It is not a place for any

sort of therapy or therapeutic environment or proper health service to happen. Thank you.

Mr. Bruce Simpson: I am very glad to be here. My name is Bruce Simpson, as I was introduced. I'm a volunteer with the John Howard Society. I have sat on the board in Ottawa, where I've lived for a number of years, and currently I'm the president of the John Howard Society of Ontario. I just wanted to tell you a little bit about what motivated me to get involved.

I grew up in a smaller community: Pembroke, Ontario. In a small community, everybody kind of knows who gets in trouble with the law and who doesn't. We know what their family backgrounds are. As I was growing up, some of my classmates dropped out of school and got in trouble with the law, and it was never terribly surprising because we knew what their families were like. And if there's anything that became clear to me as I was growing up—although in fairness I think my father, with a few remarks at times, helped me to understand that—it was that the main difference that I could see between me and those of my classmates who dropped out and got into trouble was my parents. My parents celebrated their 67th wedding anniversary a couple of weeks ago. I grew up in a happy household. It wasn't perfect and we weren't rich, but I always went to bed at night feeling completely safe. If there was anybody in the world that I felt completely and utterly safe with, it was my father. I knew that if my father was there, nothing could happen to me, or at least that's the way I felt.

But some of my friends—actually, they weren't always friends, but people I at least knew, who dropped out of school and so on—had fathers who were drunks, fathers who beat them up. And, of course, when I started practising criminal law, that's what I kept seeing. I kept seeing young men in trouble who either didn't have fathers at all because they just took off and ignored them, or fathers who were so bad that they would have been far better off without them. That made me want to do something to help the people that I was actually making money trying to help.

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Of course, what also became obvious after a while is that many of these people have serious mental health problems. Now, sometimes it's the mental health problem that's the main reason why they're in trouble with the law. Sometimes it's all of these other criminogenic factors that make them what they are that are impacting on their mental health. There's clearly an overlap between the more traditional kinds of criminogenic factors and mental health issues, and there's an interaction. When you study any science, including a social science, you learn about how things can interact. One of the difficulties with mental health problems is that they make it more difficult for somebody to deal with the kinds of social issues that get them in trouble. They're less likely to get hired, for example, and they have more difficulties in school because of the mental health problems, and of course, getting arrested, the shame that comes with that, being incarcerated, all of these things have a negative impact on mental health.

What the John Howard Society has to offer, and I think that's why it's so important to keep people who deal with people who get in trouble with the law involved in the mental health system—there are lots of people with mental health problems, of course, who never, ever get into any kind of criminal trouble, because despite their mental health problems, they have other strengths, or they may even come from very good families. Mental health can strike anybody. But the people we try to help have both the background and factors that get people in trouble with the law, with or without mental health problems, and, of course, often those criminogenic problems are exacerbated by mental health problems.

These people have learned to trust us because we have staff throughout Ontario who have learned how to gain the trust of these people. One of the difficulties that you have, and you certainly see that when you start to actually meet people who get in trouble with the law—I'm talking about constantly; any young man can get into some minor trouble. What you soon realize is that they don't really think that anybody is actually very good. They think we're all really actually criminals; it's just that some of us are luckier so we don't get caught. They think we'd all steal as long as there was no chance of getting caught. They don't think there are good people, because they haven't met them. One of the things we try to do—partly, we hope, by example, but also by other means—is to help them understand, "Look, the vast majority of people out there may not be perfect, but they're actually pretty good. Most people really are basically honest. Sure, nobody's perfect, but they're pretty good." Because they don't believe that. They have almost invariably—I'm talking about the ones who are continually in trouble. They have usually had very, very miserable backgrounds.

As for female offenders, I don't think I've had one female client, in a criminal sense, who did not have a serious abusive background. Serious offenders have almost invariably been sexually abused as children. If you've got a woman in serious trouble with the law, you can almost bet your bottom dollar she was sexually abused as a child. It just always comes out. It takes a while to get them to tell you that.

But these people need help, and they often can't get it in the more traditional—sometimes they can, but they can't always get it in the more traditional health services area, because they are not comfortable there and they have trust issues. Of course, they often need help not only with mental health issues, but also with the other kinds of issues, life skills and educational skills and so on, that even get people who don't have mental health problems into trouble with the law. So they need to get help from both of those areas. I hope and think that that's what we can offer.

Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for your presentation. I'm sure there are some questions. Just two things: At some point in the proceedings I know we heard from a delegation from John

Howard in Thunder Bay and we heard from a delegation from Kingston as well. We also received a letter as a committee saying, "We kind of feel left out of this as the John Howard Society." That certainly was not the intent of the committee. We felt we were hearing from you. Is that all cleared up now?

Ms. Paula Osmok: Thank you. I think you and I corresponded regarding that. The delegation in Kingston was a misunderstanding. I think our national director had been invited by the national mental health committee to present, and there was confusion, I think, when the person called and booked the appointment. He just assumed it was for the committee he had just received the letter for, so of course he came. I think he very clearly identified that he was not presenting in the context of the issues you were looking at but went ahead and spoke about the issues that he was concerned about in the federal prisons anyway. Yes, that was cleared up. That was unfortunate.

The Chair (Mr. Kevin Daniel Flynn): Good, so we're all on the same track.

We've heard two things, I think, going back to the very early presentations. I think we had a mother come in and say, "Thank God my son got charged, because he finally got the help he needed." We've had people come in and say, "My son can't get the help in jail. They just put him in jail and he gets no treatment at all." We've heard both sides of the story, so maybe in some of the questions you could answer that as well.

Are there any questions from members of the committee, Liz?

Mrs. Liz Sandals: Yes. A bunch of questions, actually. The statistic around 90% of women who are incarcerated having some sort of addiction issue is just astounding. Maybe on reflection it's not all that astounding. If you were going to redesign the system somehow, how would you redesign it? You tell us how you would redesign the system so that we're dealing with that more effectively.

Ms. Paula Osmok: I think two things. First, in terms of the women, the female population, I think that we need to be very cognizant that there is a specialized group, Elizabeth Fry, that also works with women. I don't know whether you've heard from Elizabeth Fry yet in your consultation process, but they are one of the community criminal justice organizations that we have worked with as a coalition and have sent you some material from. First of all, I would defer to them, although I know Bruce can speak to some of that—

Mrs. Liz Sandals: Excuse me; I wasn't specifically just talking about women, so talk about men and women, because I understand John Howard serves men.

Ms. Paula Osmok: Yes, and we do serve women as well. We just don't want to not have Elizabeth Fry recognized in the process.

I think Bruce's comments are very important ones regarding the background of a lot of women. Certainly the backgrounds, generally, in men and women who come into the system are different. There are some

glaring similarities but there are also differences, and you will find the women to be of much higher need in many cases. Generally, people who come in—there is a disproportionate number with addiction problems, we know that. In terms of turning that system around, we are very pleased with some of the efforts this government has made in terms of trying to identify those needs. Someone who enters this system, who also displays mental health concerns—there's no question they need some specialized intervention or diversion at that early entry point. It could be something whereby there has not been a diagnosis, or there has been and somebody has gone off their meds and it's simply a matter of getting some supports in place quickly. So a diversion type of initial intervention is really what's quite appropriate. Otherwise it's completely criminalizing mental health behaviours or mental health issues, which is not something we want to do. And it's a very expensive way of responding through the criminal justice system.

Mrs. Liz Sandals: What about a person who is convicted and who is then either sentenced or released, or has been on remand forever and gets convicted and more or less instantaneously released? Then they end up on your doorstep. What sort of more extensive services would you like to see provided? Because there is, I presume, a huge need there that you're trying to meet but you don't really have the capacity to meet that huge need in an ideal way. What other services would you like to see in place for those folks when they are released?

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Ms. Paula Osmok: I'll start and then I'm going to hand that to Liisa because, again, coming from an agency that's on the ground, in the trenches, if you will, I think she has a list that's quite lengthy.

First of all, I'm sensing that you recognize that, as Bruce pointed out, the John Howard Society is the go-to place for anyone being released from prison.

Mrs. Liz Sandals: Actually, that's quite true in my community.

Ms. Paula Osmok: Yes, and it's true in the prison, because when there is a request made for someone to be seen, it's made through the institutional correctional officers to see John Howard Society. So we tend to be that first stop. Coming out, there is a range of things, from the ability to do even a brief assessment, again, to access to the information and supports to monitor, supervise in not necessarily a legal or a policing-type capacity, but to provide ongoing supports where people can access services that help them to reintegrate again. It's not saying that there won't be medical issues throughout that person's time back in the community; they're going to need ongoing medical care. But the other types of supports that would come from the John Howard Society are also critical to complete that reintegration and have them live successfully.

There is some data that was gathered some years ago but has been pulled together more recently by Don Andrews and Jim Bonta, who many of you will recognize in terms of leaders in the criminal justice field, that

recognized that once those initial mental health issues are dealt with, there is great success in integrating that particular population with, generally, the criminal justice population and offering the same services, that there isn't a need to specialize once those initial concerns are addressed, which is very interesting.

Liisa, I know that you have some things you'd like to say.

Ms. Liisa Leskowi: I think top of my list of what we need that's not being funded, we need services when a person gets released. I'm always shocked that as a society we have a system where you're incarcerated—you take away someone's freedom. That's how we choose to act when someone breaks the rules of our society—you're incarcerated. If you're incarcerated, the longer you're incarcerated, the harder it is for you when you get out. You've lost your job, you've lost your family, you've lost any source of income. If you went in with distress or mental health issues, you came out with even more baggage than when you went in. And the ministry wipes their hands of you the minute you walk out that door. We struggle to get services and funding to help the offenders when they get back in the community. There's no housing; there's no funding for housing. There's no funding for a reintegration worker. Corrections will give us a contract but it's always just a little bit of money. I think as a society we need to ask ourselves, when we release someone, isn't it better to release them with supports than to just let them walk out the door? I mean, there are cases where they walk out in that orange jumpsuit, they walk out with nothing, with the clothes they wear on their back. We struggle to make sure they have a winter coat when they get out in the wintertime, released from the district jail where they're sitting on remand. That is a piece that has to change if we're going to help individuals when they get released.

The huge portion of individuals have been in jail before—once, twice, three times. It's that revolving door. Of course, when they get out and they've lost all their supports and they're going to a shelter or an organization like the John Howard Society, the Elizabeth Fry Society or the Salvation Army that recognizes the need to help people move on with their lives and make the changes—for me, that's number one.

The other piece: The research clearly shows that therapeutic interventions are best done in the community. They don't work in institutions. When parole officers try to deliver programs—and they do, but it's almost like the police that arrested you, you're now then going to go to them for drunk driving lessons. We have to recognize that there are different roles for different folks to play, and that trusting therapeutic relationship is really crucial in helping people make those changes.

The Chair (Mr. Kevin Daniel Flynn): We've got a number of other questions. I'm going to go to Sylvia, then Bas, then Jeff.

Ms. Sylvia Jones: Thank you. First let me apologize for being a few minutes late. It seems that in this building there's always three things to do in the same hour. I

know Christine is committed in the House right now, and France is attending a Franco-Ontario honouree. So it's not because of lack of interest that they're not here.

My question actually follows through on your last statement. You mentioned the interest on behalf of the John Howard Society in accessing health care funding for mental health. Knowing the chronic, continuous shortage that we have of health care professionals, and then multiplying that by mental health professionals, why do you feel it's so necessary to have the mental health dealt with within your agency? Why is the ability to open those doors, to make those referrals, not something that you would look at or recommend?

Mr. Bruce Simpson: I think there are two answers to that. Of course, in part, that is one of the things that's helpful. I know that in Ottawa, the Royal Ottawa Hospital is there. It has an excellent forensic unit, so it is possible to interact with people there. That's one way we can help our clients, by referrals.

But there are really two difficulties that our clients can have. One is that they're often not comfortable in the normal hospital setting because of their other issues that they come with and their other baggage, and having been in jail. And sometimes, quite frankly, the hospital staff aren't comfortable with them either. They'd rather not have to deal with them, because they're often not trained to deal with people with those kinds of problems and issues—the mental health part, yes. But many of our clients, in addition to having the mental health issues, also have some of the other issues that make people get into trouble with the law, and that other mental health patients don't necessarily have. They need help with their mental health issues, but they also need serious help with things like job readiness and basic life skills, and even just to understand, sometimes, why certain behaviours are forbidden and why people get upset with them. There's often a serious lack of understanding of some things.

There are people who are trained to deal with mental health issues but who also understand the other kinds of correctional issues that are involved. We have, for example, one very good psychologist on our staff at the John Howard Society of Ottawa. We need to have people like that, because then we can help people with both kinds of problems.

Of course, I don't think, in the long run, it costs a lot of money, because if we take some people away from the more traditional mental health problems, they're overbooked as well. That doesn't mean lack of coordination or lack of communication. That's important.

Ottawa is very lucky. We have an extremely good mental health centre there, and it's coordinated with the mental health centre in Brockville. But not every community has the same level.

Ms. Liisa Leskowi: If I could add to that, I'm not saying that community mental health organizations shouldn't be funded. I absolutely think they should. I think there's enough work for all of us. But the reality is, when they come through our doors—I'm unique in

Thunder Bay; I run a housing facility and they're living with me—I cannot get any support. They have two workers who will come and take a referral, and we do referrals all the time and do an assessment, but it's 9 to 5, Monday to Friday. I'm supporting this client 24/7. I use my United Way dollars to try to help me provide services.

The other issue is, I think, the traditional mental health system often refers clients to us because they're too violent. We're the ones with the expertise in dealing with the violent, criminogenic risk factors. We train our staff in that. We do serious risk assessments. Oftentimes, community mental health service providers aren't prepared to deal with this client group. This is where our expertise is. This is where we're delivering services.

But we struggle because it's so hard for us to get community funding. There's ministry funding while they're incarcerated, but it's hard to get community funding when they're released. Add on top of that the mental health concerns, and I just sometimes feel like it pushes us over the top.

We struggle to find services. I've got a staff that's got a caseload of 40. The mental health worker says, "Oh, I'm at my limit. I have five clients. I can't take your referral"—or whatever that ratio is in the health system, which is a totally different funding model. Nobody protects to make sure that I'm not over a limit, when you're in a community-based service and you're just getting foundations and United Ways to help you deliver services.

1630

Ms. Paula Osmok: If I can add as well, in response to the sorts of concerns that we're all raising with you: Our executive directors across Ontario—and that's a team of 19 people—met with a number of providers from our agencies and developed, along with our research staff, a model program that we wanted to pilot. We talked to the Minister of Correctional Services, who was quite keen on the program.

It's a post-release program, and it focuses on the high-risk, high-needs clients, many of whom have mental health problems. We wanted to pilot it for a year or two, follow it with a very rigorous evaluation and see what difference it made in terms of their recidivism, and also measure the cost savings based on a lit review that we've done and some research into service costing, because we believe that, with an ongoing worker and providing the kind of services that Liisa's talking about, we can prevent them from getting back into the system.

If you think about it—and I know you're well aware that oftentimes, a behaviour outbreak or outburst results in the police being called, and they are either formed, they're held in jail, or they're back-breached and they are in prison. The cost of those interventions, including a possible stay in emerg or a referral to another hospital, is huge.

We honestly believe that with the types of interventions we do, we can reduce that down to a very manageable number, and a program like that would pay for itself many times over in a very short time frame.

We met with the Minister of Finance as well, and we recognize the budget constraints, but we honestly think that if we could scale down and do this in a very small pilot way and perhaps look at Toronto and Thunder Bay, where, of course, with the disproportionate aboriginal problem in the Thunder Bay area and the diverse population in Toronto—and Toronto, as you know, is also, for lack of a better word, a bit of a dumping ground; a lot of people come to Toronto who have nowhere else to go or no supports at all—these would be two communities that would really lend themselves to being monitored and researched, evaluated around an intervention like that.

That's something we'd be very happy to submit to you, what we have put together in sort of an overview kind of way that wouldn't be too extensive for you to read, to let you know and partly answer a list of your questions: What kind of interventions would work and what are the alternatives to the traditional siloed approach that we're seeing right now?

As Liisa points out, there clearly is some resistance from the Ministry of Health-funded agencies in the community. Although there is some working together, and some referrals are accepted, there really is some resistance to what we would say is a very effective working relationship in the community with other community-based agencies.

The Chair (Mr. Kevin Daniel Flynn): We have a very short amount of time left, and we've got Bas and Jeff. If these can be really quick and short answers, that would be great. If not, we should just call it right here.

Mr. Bas Balkissoon: I've just got two quick ones. You talk about funding; can you tell us, other than the United Way, where you receive the majority of your funding or other funding from? On this document, you have some recommendations here. In the third bullet point, can you tell me what the abbreviation HJCC stands for?

Ms. Liisa Leskowi: Yes. It stands for the Human Services and Justice Coordinating Committee. Those are committees that were set up under the last round of provincial funding that went for mental health that went to health-funded organizations. They coordinated these committees across the province.

It's all mental health, and I think, Kevin, what you've picked up on is, we've been trying to get to the table, and there's such resistance to include us in that because that's seen as health. They sent a provincial response—I chair our local committee, and my response that you see in that bullet point was saying, "Reject their recommendation that money for this initiative should only go through health." We're saying it needs—

Mr. Bas Balkissoon: Do you know which ministry conducted that?

Ms. Liisa Leskowi: Conducted the—?

Mr. Bas Balkissoon: The human services—

Ms. Liisa Leskowi: It was a joint committee of a number of ministries that got together, and I think all the funding now for this flows through the LHINs from the Ministry of Health.

Mr. Bas Balkissoon: Okay. And the other one is, who do you currently get your funding from, other than the United Way?

Ms. Liisa Leskowsky: We have tried really hard to be part of that initiative. I've worked really hard. I'm really passionate about this, and we still feel like we're on the outside. For all of the services that are happening right now in the province of Ontario and the provincial dollars that have been allocated to mental health services, it all still flows to mental health agencies.

Mr. Bas Balkissoon: No, my question is, you've mentioned you receive funding from United Way. Is there any other source of funding to your particular organization?

Ms. Liisa Leskowsky: We have numerous funding for all the various programs. For the discharge community-based pieces, it's only United Way for my organization.

Ms. Paula Osmok: If I can add a little bit to that, taking into account the funding situation with all of the John Howards across Ontario, that would be the case. But United Ways, as you may or may not have heard, are moving into a different model of distributing funds and allocating funds. First of all, it's a donor designation model. So motherhood organizations that are very easy to support tend to be pulling in lots more dollars from United Way, and they also are finding a level of discomfort around criminal justice populations; they have for a number of years. It's really a major effort that has to be made to convince them, so that United Way funding is slowly disappearing.

John Howard of Ontario has a direct mail campaign that we administer, and we distribute that funding back out to our affiliates for institutional pre-release work to try and do at least as much as they can in the institution and have things in place on the outside when they are released. But that amount of money is \$65,000 that is distributed. Obviously, it's just a very small amount, and we distribute based on both need and institutional release populations across the province, so it's really insignificant.

There are two, I believe, discharge planning contracts that allow, through maybe looking the other way from the ministry, a minor amount of help in the community, but I think that's only two across the province.

The Chair (Mr. Kevin Daniel Flynn): Jeff, final question. If you could make it brief.

Mr. Jeff Leal: It will be two quick ones. The percentage of clients that are First Nations individuals?

Ms. Liisa Leskowsky: In Thunder Bay? Across our programs it probably averages between 55% and 60%.

Mr. Jeff Leal: Between 55% and 60%.

And every group that has made their presentation to us over the last many months has talked about silos. Have you got any good suggestions on how to blow up these silos? Sorry to put you on the spot, but I want to know.

Ms. Liisa Leskowsky: You know what I think? I think that it has to come from the ministry. I think it has to come from a government level. I think how you fund in a competitive environment, making agencies, number one,

compete against one another for contracts—if we're going to fund social services that should be funded, "This is what we need to fund, this is the resources, this is who's doing the work, here's the funding for it." I think that silo structure is a by-product of how funding is distributed.

In terms of how do we—and at ground level now that we're not going to be able to change that very quickly, I would recommend that we take resources and we share the resources, we ask organizations to collaborate, but the resources are shared amongst organizations.

Mr. Jeff Leal: Do we have too many organizations?

Ms. Liisa Leskowsky: No. There's more work that needs to be done. The work is huge. It's not like one of us can do it. One sector can't do it by itself. We all need to work together.

The Chair (Mr. Kevin Daniel Flynn): Thank you for coming today. It was really appreciated.

Ms. Paula Osmok: Would you like us to submit our remarks to you? I guess you've got them captured through Hansard.

Interjection: The gentleman at the back there has got it all down, word for word.

The Chair (Mr. Kevin Daniel Flynn): Thank you, and thanks for your patience.

Mrs. Liz Sandals: Can we figure out a way to open the windows so we can breathe?

Mr. Bas Balkissoon: They're open already. Nothing is blowing this way.

1640

SCHIZOPHRENIA SOCIETY OF ONTARIO

The Chair (Mr. Kevin Daniel Flynn): Okay, our next presenters are from the Schizophrenia Society of Ontario. Have a seat anywhere you're comfortable. Thank you for your patience; thank you for waiting. We fell behind a little bit in our schedule today. If you could leave a little bit of time at the end for questions—you saw the last presentation. Often there's more—

Interjection.

The Chair (Mr. Kevin Daniel Flynn): Yeah, they have a lot of questions. I'm not trying to tell you what to do, other than you've got a very curious group before you here. Having said that, it's all yours.

Ms. Vani Jain: Do you mind just giving us two minutes to get connected? Is that okay?

The Chair (Mr. Kevin Daniel Flynn): Are you the starting speaker?

Ms. Vani Jain: Yes.

The Chair (Mr. Kevin Daniel Flynn): Okay, go ahead.

Ms. Vani Jain: In the interest of time—this might take a few minutes to set up—we're happy to go ahead with the handouts, if that's better for you.

The Chair (Mr. Kevin Daniel Flynn): Yes, if that works for you. It's just my fear is, we're a little bit behind already, obviously, and we don't want to fall any

further behind. But I don't want to make you uncomfortable in your presentation either.

Ms. Vani Jain: No, I'm fine, as long as everyone else is.

The Chair (Mr. Kevin Daniel Flynn): Okay. We're all yours. If you could introduce yourself for Hansard before you speak, that would be great.

Ms. Vani Jain: First off, we just want to thank you for inviting us here to present on the topic of mental illness and the correctional system. This is an issue that is of great concern and interest to us.

By way of introduction, my name is Vani Jain. I'm the manager of policy and community relations at the Schizophrenia Society of Ontario. I was here last September, presenting along with our executive director, Mary Alberti.

Sheila Deighton is our regional coordinator in the Ottawa office. She also sits on her local human services and justice coordinating committee. She's also a family member and will be speaking from that point of view today. Alistair Deighton is Sheila's husband, and has lived experience with both mental illness and the criminal justice system. So Sheila and Alistair will be sharing their experience with the correctional system.

To the next slide: briefly, just a little bit about our organization. Our mission is to improve the quality of life of those affected by schizophrenia and psychosis, through education, support programs, policy and research.

Our justice and mental health program works with families of people with mental illness who are in contact with the law. Mental health and justice is a priority area for our public policy department as well.

I should note, before we begin, that our presentation is based on our own experience with the correctional system as a mental health agency, and our own review of this topic. The data provided in the presentation are drawn from other sources, so while we will do our best to answer your questions, we may have to get back to you on a couple of things.

To the next slide: We wanted to start by giving you a snapshot of what the correctional system looks like. Overall, there are 31 institutions in the province. Ten of these fall into the category of correctional centres. These house individuals with sentences of 60 days up to two years less a day. Offenders in correctional centres are eligible for education, counselling and work experience programs.

Four of these 10 institutions also serve as treatment centres, which is where those with the most pressing mental health concerns go for specialized services and treatment. St. Lawrence Valley in Brockville, which you may have heard about, is an example of a treatment centre in the correctional system.

Finally, there are 21 jails and detention centres. Jails are typically older, smaller institutions, while detention centres are larger and more modern and serve the needs of an entire region. These institutions are for individuals who are sentenced to less than 60 days, are on remand or awaiting transfer to another facility.

Overall, these 31 institutions across the province serve 8,900 inmates.

To the next slide: We're just going to give you a little bit about the inmate population. The Ministry of Community Safety and Correctional Services estimates that approximately 63% of its inmate population is on remand, which means that they are in detention during their court proceedings, awaiting sentencing.

In their presentation to you, the ministry indicated that about 50% or more of these inmates on remand are released within eight days, which is certainly true. However, the other 50% or so can be there for any length of time. That can be quite long; we ourselves have seen remand periods of even 20 months. Inmates with mental illness may have longer remand periods if they have delays in their trial associated with their mental illness. The unpredictability of the length of remand time poses some serious challenges which we will discuss later. It should also be noted that the ministry estimates in their latest strategic plan that about 15% of inmates require clinical intervention for mental illness.

Moving along to some of the prevalence data, there has been a number of studies conducted worldwide looking at the prevalence of mental illness in correctional facilities. These all use different methodologies and different samples.

The data that we've provided for you here is based on a study from Dr. Greg Brown at Nipissing University, which specifically looked at provincial correctional institutions in Ontario, so it's the most relevant data that we have. In its face-to-face assessments conducted with 522 inmates, his study showed that 6% of men and 5.7% of women had a diagnosis of schizophrenia, and 12.7% of men and 24.5% of women had a diagnosis of mood disorder. An examination into the symptoms of mental illness, which may provide a more accurate picture of the prevalence of mental health issues than diagnosis, indicated that 5% of inmates demonstrated a high number of severe symptoms, and 35% of inmates demonstrated a moderate number of severe symptoms.

What we draw from that is that the prevalence of mental illness in correctional facilities is much higher than in the general population. For example, 1% of the general population has schizophrenia versus 6%. Substance abuse rates are also much, much higher, as much as eight times that of the general population.

That gives you an idea of who these inmates are with regard to mental illness. In terms of the correctional system's capacity to treat mental illness amongst inmates, there are 220 full-time health care employees, not including managers. This figure includes 11 psychiatric nurses, meaning that not all institutions have a psychiatric nurse on staff. Nine of the 31 institutions have designated special-needs units for vulnerable inmates with cognitive and/or mental health needs so that they can be housed separately from the rest of the population. Three out of the 31 institutions also have infirmary units, which are for people whose needs are much more intensive. Of the 31 institutions, nine provide mental health care

services 24 hours a day, seven days a week, while the rest have 16-hour-a-day mental health service.

At this point, we're going to turn to our understanding of what's actually happening in the correctional institutions. The first area that I will go over is screening. The importance of screening new inmates is clear, both for the purposes of inmate classification and to ensure that those who have pressing mental health needs are flagged so that these needs are addressed. In Ontario, new inmates do receive a medical assessment which is meant to screen for mental health issues as well. This assessment is supposed to happen immediately, but this may not always be the case, depending on when the inmate enters the facility. If the individual is flagged for mental illness, this may initiate a more in-depth mental health assessment, but this practice, to our knowledge, is not formalized, and it can vary from institution to institution.

The literature recommends a two-stage screening and assessment process as the best way to effectively identify those with mental health concerns, which would subsequently inform treatment and correctional plans. As an example, the Correctional Service of Canada has recently moved to a new formalized two-stage process called the computerized mental health intake screening system. Stage one involves a brief screening; it takes 30 to 40 minutes to complete, and it's self-administered. If the individual is identified as presenting symptoms of mental distress, they'll go on to stage two, which is a more in-depth assessment.

Really, what we're trying to say here is that unless we know which of our inmates have mental health concerns, we can't properly address those concerns, thus making mental health screening a really vital part of the whole correctional system.

1650

Moving along to treatment: In terms of treatment, as mentioned, all institutions have some health care professionals on staff, including psychiatrists and psychiatric nurses. The exact staff complement varies by institution. One good thing to mention is that all inmates have health care coverage through OHIP, and those who don't qualify can obtain temporary coverage.

In our view, one of the challenges is that psychiatrists really seem to only have the capacity to address pressing medical needs—in other words, basically prescribing and monitoring medication. They're not really able to go much further than that.

For those who enter the facility without a prescription or who have their medications confiscated for whatever reason, these individuals may not be able to access medication for several days. What we know for our folks is that this can mean significant decompensation over that period. The psychiatrist in the jail might also prescribe a new or different medication which the individual may have some difficulties adjusting to, especially given the setting that they're in, which is not a particularly supportive environment.

SSO obviously sees a need to provide greater access to comprehensive psychiatric care for its provincial inmates.

Another interesting thing—and I'm drawing some parallels to the Correctional Service of Canada because there's quite a bit of movement at that level. One thing that they're doing is, they've recently introduced telepsychiatry for their federal inmates. This allows the inmates to be connected to a psychiatrist in the community via video conferencing. That type of video conferencing is frequently done for court proceedings. The technology may be very well available. The program is quite new, and our suggestion is that this be evaluated and monitored with a view of possibly instituting it in provincial institutions as well, as it may be quite promising as a way of providing access to psychiatric care.

Moving to mental health programming: As mentioned, programming is available in correctional centres for sentenced offenders. Inmates on remand, however, do not have access to this type of programming, which can be very problematic. While many of them are released quickly, others are there for a long period of time and would definitely benefit from the type of programming that is offered in other institutions.

One of the specific needs that has been raised with us with regard to programming is really a need for more psychosocial programming for inmates, such as behavioural therapy. Addictions counselling was another important need that came up, as so many of the inmates with mental illness also have co-occurring substance use issues. If the addictions issues are not addressed, the individual is much more likely to re-enter the community and use again, putting them at risk of reoffending. It's really important that those issues are addressed in the institution as much as possible. Overall, we feel that comprehensive programming is necessary for all inmates in order to help them gain insight into their behaviour and prevent recidivism.

Like in the community, medication is one part of treatment, but it's not the only part. Individuals with mental illness should have access to a more holistic approach to treatment and care. One way to facilitate this may be more community and corrections partnerships. This could include programs where a community mental health agency goes into the institution and delivers the service themselves. This would also help facilitate more communication between correctional staff and community agency workers. It's a model that we've seen to be really effective in the context of hospitals and community agencies, in the sense of facilitating that communication and making sure that the transition from the institution to the community is much easier.

The next slide is about suicide prevention. Recent incidents such as the Ashley Smith suicide, which happened at a federal correctional institution, have highlighted the need for corrections to better protect inmates from committing suicide. With suicide rates in jails and prisons at 10 times that of the general population, suicide amongst inmates simply cannot be ignored. We have concerns that solitary confinement is overused and may be seen as the only option for addressing inmates with mental illness who are exhibiting "bad behaviour." It

may also be used for people who are believed to be suicidal, as these strip cells, as they're called, do not provide the inmate with anything that they could possibly commit suicide with. So you're really seeing people put into six feet by six feet boxes, with nothing. What we know is that this type of setting is inhumane for people with mental illness in particular and that it can actually make the situation worse, not better.

A more appropriate suicide prevention policy would be based on risk management. New inmates should be assessed for their risk of suicide upon entry, and then again as red flags are raised. These individuals should be provided with counselling and possibly even a psychiatric bed, but not put into a strip cell.

Howard Sapers, the Correctional Investigator of Canada, has recommended that the federal segregation policy be amended to require psychological review and assessment of risk for anyone being put into solitary confinement, which we think should be applied at the provincial level as well. We've also supported recommendations that solitary confinement be used only as a last resort, and for as short a time as possible, and that inmates have access to mental health services which would more appropriately address their mental health needs and reduce correctional staff's dependence on solitary confinement.

Next is release planning. Proper release planning is essential if we expect people to be successful in the community upon their release. However, many institutions do not have the internal staff resources to commit to comprehensive release planning. They may also not be able to attend to the special needs of inmates with mental illness that they would have in the community. What we're seeing is too many people falling through the cracks as soon as they re-enter into the community because they were not connected to the appropriate resources or treatment supports.

One approach to address this issue is release-from-custody programs. These programs, offered through community mental health agencies such as CMHA and COTA, have staff that help develop release plans for inmates with mental illness. Typically, these release planners will obtain referrals from correctional staff as soon as the inmate enters the institution, or as soon as possible. They can be referred inmates on remand as well as sentenced offenders.

The release planner goes into the institution, meets with the individual, discusses what their charges were, what supports they have, what supports they would need in the community. This includes things like housing, treatment, even ODSF applications. For sentenced offenders, they would take into account the release date, and, for those on remand, they're still able to work with those clients. What they do is, they keep track of their court proceedings and try to kind of estimate when the person will be released. So it is a service that can be provided to those on remand. The release planner then continues working with the individual for up to six months in the community to ensure that they are connected with the services that they need.

On to the next slide: Release planning is only effective if the appropriate community supports are available. The main challenge for release planners is that there are not enough, or the right type of, community services for their clients. The system simply does not have the capacity to meet the needs of these individuals.

Another challenge is that individuals with criminal histories may be labelled as "high risk" and actually screened out of community programs and doctors' offices. So this is a stigma issue that needs to be addressed. However, we may also need to look at funding for programs that are geared specifically towards individuals with past criminal histories and have the right staff and resources to support those individuals.

Waiting lists for service as well as intake procedures that require face-to-face assessments in order for a person to be accepted into a program are also a barrier for inmates who need a release plan.

Just a couple of other quick issues of concern before we move on to our other presenters—two issues that we wanted to mention quickly. The first is victimization and abuse of inmates with mental illness in correctional facilities. In a jail setting, individuals who are visibly different or whose behaviours may be interpreted the wrong way may be at risk, especially if they're not properly identified during intake and actually put into the general population rather than a special-needs unit. The killing of Jeffrey Munro at the Don jail last November is an example of the worst possible consequence of what can happen with victimization.

The second issue is the lack of family involvement. Whether we're talking about the individual's time spent in the institution or their transition back into the community, family support or support from friends or anyone, when available, is crucial. Yet there are many barriers that families and friends face in staying involved with their family member in the correctional institution.

For example, a policy of collect calls only can be a huge financial burden on a family that really wants to stay involved with their family member. They may also have difficulty calling in to talk to their family member in the institution. They may also have challenges communicating with the correctional staff about how their family member is doing, just calling to see, "Is everything going okay? How's he doing?"—that kind of thing. It can also be frustrating to not be informed about important decisions, such as their family member's release, especially when that person is coming back to live with them.

Staying on the theme of families, I'll now turn it over to Sheila and Alistair to tell you about their personal experiences. I think we're going to start with Alistair.

1700

Mr. Alistair Deighton: Hi. My name's Alistair, and it started off in the Cornwall Jail, from January 31, 1995 to April 10, 1995. I should have taken extra medication before I came here.

I was remanded to the Cornwall Jail awaiting a psychiatric assessment bed at the Royal Ottawa Hospital.

The Cornwall Jail was built in the early 1800s. The cell was crowded: three people in a two-man cell. I slept on a mattress on the floor with my head right by the toilet. I was afraid that if I slept with my head by the bars, my head would be kicked, in that inmates kept threatening to get me.

At one point, I was given an antidepressant medication, but the guards would open the capsule and put the powder in a Dixie cup for me to take with water. The medication would burn my throat for about one and a half hours afterwards. I was only allowed two visitors a week, a maximum 20 minutes per visit.

I was paranoid, so I warned anyone who came to talk to me that they were listening in. I was very suspicious of one of my cellmates. He was writing things down all the time and I thought that he was spying on me. I was in a very bad state of paranoia. I did not see a psychiatrist while there.

Admission to the Royal Ottawa Hospital: April 10, 1995 to November 1995. On April 10, I was admitted to the forensic unit of the Royal Ottawa Hospital for a court-ordered assessment. I was so ill, I was found to be unfit for trial. I was diagnosed with schizoaffective disorder. I received treatment of antipsychotic medication. Within two months, with treatment, I became fit for trial. I remained at the Royal Ottawa until late November, when I was remanded to the Ottawa-Carleton Detention Centre, pending my trial in March 1996.

Ottawa detention centre, 10 days at the end of November 1995: When I was transferred there, I was placed in a segregation cell with no heat and given a silver sheet and nothing else. I was freezing. I stayed overnight like that. I was so cold that, in the morning, I told the guards I didn't care where they put me as long as it was warm.

I should have gone into segregation, but I went into the general population where the environment was threatening, violent and I feared for my safety. The stress of this environment caused me to relapse. On a court order, I was readmitted to the Royal Ottawa Hospital, where I remained until my trial on March 19, 1996, when I was found to be not criminally responsible due to a mental disorder.

When we talk about—

The Chair (Mr. Kevin Daniel Flynn): Take your time. There's some fresh water there and some glasses.

Mr. Alistair Deighton: When we talk about fear, when I went to the detention centre after the night of freezing, they put me in with the regular population. They gave me a roll, which was a mattress and a cloth blanket, and I was told to go to such and such a cell and such and such a bed. So I went in there, there was nobody there, but just like that, bang, a guy came running in and he said, "What are you in here for?" I said, "None of your business." He said, "What are you in here for?" I said, "None of your business." This went on for about five or six times. Then all of a sudden, two guys came by the door. So I'm facing this guy in front of me, and I'm facing two guys over here. What are you going to say? What are you going to do? So I said, "I'm here because

of murder." The fellow turned around to me at the door and he said, "Oh, murder. Is that all? Well, that's okay. Pleased to meet you."

That made things a little bit easier.

Later, before I left, the fellow who first of all presented himself to me and demanded things of me said, "I was rather impressed with the fact that you stood up for yourself." Luckily, I had the sense to make sure that I did stand up for myself, because if I didn't, I would subsequently have been treated in a very poor way.

For example, one of the problems is my age. Most people who are in jail are much younger, so they assumed that I was a pedophile because of my age. Well, there was a pedophile in there, he was down at the end of the range, and whenever the guys felt like having a punching bag, down they went and they just punched the hell out of him.

Anyway, that's my story. I can only say that my wife helped me out, because when I was in the Cornwall Jail, I was sent back once from Ottawa. Dr. Bradford had given them—

Ms. Sheila Deighton: A list.

Mr. Alistair Deighton:—a list of what medications I was supposed to have. Well, while I was there, I wasn't getting these medications. So I had been medicated, brought to the point where I was no longer suffering from psychosis, sent back to jail, not given the medication, so I started to become psychotic again. Well, thank God, I called my wife and I told her what was happening, and she called Bradford, they called the jail and, just like that, I had my medication.

Anyway, that's my story. Thank you for listening.

The Chair (Mr. Kevin Daniel Flynn): Thank you for telling us. Sheila, did you have something to add?

Ms. Sheila Deighton: I'm here today to speak as Alistair's spouse and as a family member and the work I do with families at the schizophrenia society.

Alistair, as he shared with you, was charged with murder. He had a complete psychotic break and he killed our son. He was under the care of a psychiatrist at the time who was not treating him with medication. He was just using talk therapy. That's similar to a person who has type 1 diabetes not being treated with insulin.

In Alistair's family, there's a long history of psychiatric illness. His mother was diagnosed with schizophrenia when he was four. His grandmother had schizophrenia. Our son that died was displaying symptoms of mental illness; he was 18 and had made a serious suicide attempt. But the mental health system failed our family, because we were told, even with our son's suicide attempt, that he was 16, and he refused admission to a hospital. He jumped 30 feet, he hemorrhaged and nearly died. Six days later, they discharged him from hospital to a family who had no support, no education, nothing; to a father who was struggling to cope with work and family, and no treatment. So what did it take to get help and care for our family? It took this.

Unfortunately, our access to treatment came through the forensic mental health system and the criminal justice

system. He spent two and a half months incarcerated, sleeping on a mattress because of the waiting list to get into the forensic bed at the Royal Ottawa Hospital. There are so many people—there were 20 people ahead of him. Every day I would call to find out, “Where is he? Has he been transferred yet?”

1710

Finally, when he got transferred, and he was transferred into the hospital, that’s when our life changed. That was a new chapter for us. He was in a therapeutic environment, provided care by professionals who didn’t look at what he was charged with but looked at him as an individual, professionals who looked at our family as a whole, who provided support and education for myself and our two surviving children. And he got treatment.

I had an opportunity to read through your interim report, and I noticed in the report that I kept seeing that people need “a home, a friend and a job.” Yes, they do. But first and foremost, they need medical treatment. Without that foundation, they’re not going to be able to sustain a job or a home, and they’re going to lose their family. So it’s not one piece; it’s a complex puzzle.

I can speak from personal experience. Alistair spent 18 months in the forensic unit at the Royal Ottawa Hospital. I was like Joe Public and had very limited knowledge of mental health, had a tremendous amount of fear. But spending that amount of time in that hospital, I had an opportunity to see traumatized families who were supporting loved ones who were not functioning, who were suicidal, some of whom had committed serious offences, others minor. I saw them go from a state of incapacity and poor quality of life to people who got their life back with treatment, with medication, with therapy, with support.

Thank goodness Alistair spent that time at the Royal because they were able to—as he said in his statement, he was so ill that he was unfit for trial when he was transferred to the Royal. With treatment, he responded well. But when he responded, he started to have insight into what he had done, and thank goodness he was in a therapeutic setting and we had that type of support as well.

Today, I’m sorry to say, I take the same calls from families. I take calls from families who have exhausted all avenues of trying to get their loved one into care, because we have a system that respects an individual’s right to be ill until they become homicidal, suicidal or incapable. Sometimes, I have to tell them, “If there’s an opportunity to charge this person, you might have to do that.”

But at the same time, I prepare them for the fact that if they end up remanded in a correctional facility, they may be there for 10 weeks. I have gone to court with families where they’ve had to take that step, and the mother is crying because her son is in the prisoner’s box, he’s lost 20 pounds, he’s unshaven, he’s dirty, and she feels guilt. But at the end of the day, going through that system, it’s painful at the time, but getting treatment through the forensic mental health system, you have good positive outcomes.

Mr. Alistair Deighton: One thing I would like to mention is that when somebody with mental illness does a criminal act, what happens is that the lawyer will tell him that he can get out quicker if he takes the criminal route. If he takes the mental health route, he’s going to be incarcerated for a longer period of time under the ORB. It’s a crime, because we have people being criminalized who shouldn’t be criminalized.

The Chair (Mr. Kevin Daniel Flynn): Our committee is looking at what the new system is going to—what we need in Ontario. We’re trying to look at it in some cases through the eyes of an average Ontario family. You must have met as a young couple, decided to get married and, at some point, had three kids. At some point before the children, did you know that you were going to be dealing with this, Alistair, when you were a younger person?

Mr. Alistair Deighton: I walked into Dr. Bradford’s office, and all of a sudden he was telling me things I didn’t know. He told me that I was in the hospital, at the Jewish General in Montreal; I had no memory of that. He told me that I had been at a psychiatric hospital here in Toronto; I had no memory of that whatsoever. Because my mother suffered from schizophrenia, my father and my stepmother—what’s the word when they—

Ms. Sheila Deighton: Stigma.

Mr. Alistair Deighton: They stigmatized me, right? I felt stigmatized because of the fact that my mother suffered from schizophrenia. But I got by, and the reason I got by is I’d turn to my wife and I’d say, “Am I seeing this right? Is this what’s happening?” and Sheila would say to me, “No, Alistair. That’s not what’s happening; this is what’s happening.” So this is how I was able to get along. This is how we were able to maintain the household as it was. It didn’t come into our marriage in front of us until my son started to show signs of schizophrenia.

Ms. Sheila Deighton: It was when our son, at the age of 15, started to have, really, behaviour that was a major concern for us. We tried to get help for him, but we were told by the mental health professionals that we were controlling parents and that we had a communication problem and a power struggle in our home, despite the fact that we presented them with the family history of mental illness.

The Chair (Mr. Kevin Daniel Flynn): So as an individual, did you know that you were going to have to deal with this when you married Alistair?

Ms. Sheila Deighton: No.

The Chair (Mr. Kevin Daniel Flynn): This was something that just hit you like a ton of bricks?

Ms. Sheila Deighton: Well, I knew that Alistair had a very traumatic childhood as a result of his mother’s illness. When he was four, she had tried to kill him and his sister. They lived in Montreal, and she had to be institutionalized. That was in 1949, when there was not very much treatment available. Alistair and his siblings were separated and sent off to different parts of the family, and they really had no family life, I would say, until he was about 16. So after I met Alistair, there were

some things that were different, but I had attributed that to his childhood.

As I said earlier, I really hadn't given much thought to this being a risk. In fact, Alistair's father and stepmother were visiting us, and they said, "Oh, if you're thinking of having children, don't worry. We had Alistair examined by Dr. Walter Penfield in Montreal"—this was in the 1950s—"and he said, 'Don't worry. The kids haven't inherited the mother's genes. They're not going to have schizophrenia.'" I said, "Okay; cool. That's okay."

Alistair did have some difficulty. The psychiatrist who was treating him did start seeing him in the mid-1970s, because he was having difficulty coping, and he was told at that time that he needed to grow up, that life wasn't black and white.

So our interaction with psychiatry, both at the youth and adolescent level and private psychiatry, was not good. In fact, Alistair didn't have an actual diagnosis until he was in the forensic unit and Dr. Bradford diagnosed him with schizoaffective disorder with a major anxiety disorder.

Mr. Alistair Deighton: That's why I should have taken more pills before I came here.

The Chair (Mr. Kevin Daniel Flynn): You did a very, very good job.

Are there any questions? Liz.

Mrs. Liz Sandals: If this is too personal, don't answer: If I'm understanding correctly, the reason that you weren't on meds was that somehow, the psychiatrist with whom you were working had totally missed the fact that you were schizophrenic and should have been on meds. They were sort of going after this very troubled childhood and treating it as some sort of therapeutic thing you needed to talk through, and he totally missed the fact you were schizophrenic?

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Mr. Alistair Deighton: I think he believed in Jung and he believed in Freud. That was what he saw as the answer and the way through. So he didn't realize that it is a mental disease—like, you break a leg; I broke my brain. If you break a leg, you get a cast. I broke my brain, you have to get medication.

Mrs. Liz Sandals: So this wasn't a case of—because a lot of the situations that we've heard of are perhaps more like the problems around your son: somebody refusing meds and nobody being able to say, "No, no, you need the treatment." This really wasn't a refusal of meds; it was just a total miss on the diagnosis.

Ms. Sheila Deighton: And actually, following my husband's trial and the trial of NCR, I filed a complaint with the Ontario College of Physicians and Surgeons. They brought in a private investigator to investigate, and the outcome was that they found the psychiatrist failed to meet their standard of care, which was fairly significant. That was a long, painful process, I have to tell you.

Mrs. Liz Sandals: Thank you so much for sharing with us. It's a very difficult story.

Ms. Sheila Deighton: This is why we're doing what we do. We all are working towards making this system

the best we can make it. If in telling our story and putting a human face and a family face—because this affected Alistair and our entire community. We live in a rural community, and I have to tell you, I had strangers coming to my door to find out how he was doing. They would share a story about a daughter who lived in Toronto who was ill. Everybody—we're not immune to this illness.

The Chair (Mr. Kevin Daniel Flynn): Sylvia?

Ms. Sylvia Jones: Just very briefly—and I guess I should ask Vani this question. You mentioned in your document about release planning: "Community 'release from custody' programs help develop release plans and support individuals in the community." That makes sense to me. Yet what surprised me was the organizations that you named.

I'll put this to you and Alistair. As you transitioned from sentencing and custody back into the community, was there ever a role that was played by other agencies—the John Howard Society? Can you sort of expand on what happened at that point?

Ms. Sheila Deighton: I can speak to that. Actually, because Alistair was found not criminally responsible, he then was transferred out of the justice system into the forensic mental health system. We didn't have any interaction with any agencies at all. The transition was managed through the forensic unit of the Royal Ottawa. Basically, following his finding, he was returned to the Royal Ottawa Mental Health Centre, where he awaited the outcome of the Ontario Review Board hearing, which determined where he would stay and what his treatment would be. So he was under an order from the ORB, and that was managed through the Royal Ottawa Mental Health Centre and the Royal Ottawa Health Care Group.

One of the things that is true with the forensic system is that you have accountability. The Royal Ottawa Health Care Group is therefore accountable for management of this individual. As he transitioned from the hospital into community living, it was a step-down process, where they felt he was stable, he was discharged to a supervised home, but he relapsed within five days. It was the anxiety of the move from the hospital to the home, and I was in Dr. Bradford's office with Alistair. Alistair was sitting there, and his hands were going, his tongue was going and he was rocking. Dr. Bradford looked at me and said, "If you and I were on the medications he's on, we'd be on the floor. I can see that he's really agitated, and I can't leave him in this condition." He picked up a phone and Alistair was back in a bed in five minutes.

Ms. Sylvia Jones: I appreciate your sharing this, because it clarifies a lot of questions that we've had over the last couple of months.

Ms. Vani Jain: Just if I could add very quickly with regard to the actual release-from-custody programs that I mentioned: There are a number of agencies that do offer them. CMHA and COTA are a couple of those, but they're specifically for people who are in correctional institutions. Sheila is talking about the step-down process for someone in the forensic system, which is actually

much more gradual. But for people in correctional institutions, this is sometimes the only way that they can really be connected with the services that they need. These programs are fantastic; they're just not offered everywhere.

Ms. Sylvia Jones: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you for coming today. It was really appreciated.

Ms. Vani Jain: Thank you.

Mr. Alistair Deighton: Thank you all very much. We appreciate it.

DURHAM REGIONAL POLICE SERVICE

The Chair (Mr. Kevin Daniel Flynn): Our next delegation is from the Durham Regional Police Service. If you'd like to choose your chair. Thank you all for being here today. Before you speak, and when you speak, if you would each identify yourself so that the folks at Hansard know who's saying what.

We've fallen behind a little bit on the time because of circumstances out of our control. Everybody had something else to do in the House today, and the House is a busy place. Also, at 10 to 6, we're all going to have to go and vote. So if the bells start ringing and we jump up and run out of the room, it has nothing to do with what you've said; it has to do with what we need to do.

Can you give me some idea of what you're planning on doing, and maybe we can—you're going to give a presentation, obviously.

Ms. Wendy Stanyon: Right. We've come to show you an educational product that we've developed as a team to educate police. We really wanted to show you a demonstration of the simulation. That was our primary reason for coming.

The Chair (Mr. Kevin Daniel Flynn): Wonderful. I don't want to break the presentation halfway through. How long would the opening part of the presentation take?

Ms. Wendy Stanyon: Five minutes or so. It's just a short intro.

The Chair (Mr. Kevin Daniel Flynn): Okay.

Mrs. Liz Sandals: Why don't we start, and if we get up, we'll look at the last part—

The Chair (Mr. Kevin Daniel Flynn): Okay, yes. You guys start, and then at the appropriate time, we'll run away and come back.

Ms. Wendy Stanyon: Okay. I'm Wendy Stanyon. I'm from the University of Ontario Institute of Technology. Thanks very much for having us today. We're here as a team to show you what we developed in terms of police education.

Just to highlight our partnership and how it happened: It's quite unique, in that the Durham Regional Police Service contacted me, as a nurse with a mental health background, and asked for some assistance because they had had some problems with how officers were responding to the mentally ill in the community. I thought it was a really courageous act on behalf of the police service.

We started working with them and educating front-line officers. Over time, we partnered and applied for

funding, and this is the result of the funding that we received. We built some simulations that are to assist officers in learning how to interact with mentally ill people in our community.

1730

We've got all of our partners here. The novel part of this is that it was designed by front-line officers in conjunction with us. So they sat literally writing the scripts from real-life incidents that they experienced in the community. They are the police in the simulations. The clients in the simulations are role-played by nurses from Ontario Shores, who know the behaviours quite well. So what we found is that the level of realism from the police perspective was really good. I'm thrilled to be here with our partners, and I think it's quite a unique partnership we have.

Ms. Marjory Whitehouse: I know you're very anxious to see the simulations. My name is Marjory Whitehouse. I am the risk manager at Ontario Shores Centre for Mental Health Sciences. I just want to speak briefly. The product is a wonderful product, but maintaining this partnership had a major influence on how we did business. More importantly, it affected how responses to the mentally ill in crisis in the community were dealt with. It also afforded the opportunity for two different sectors to get to know each other, because often we did interface—health professionals and police—and not always on very pleasant circumstances. However, through this process, we got a greater understanding of our respective roles.

What we have heard anecdotally as a result of the education is that visits to ERs have been reduced in our area. So overall, we feel we've contributed not only to, from Ontario Shores' perspective, creating a stronger alliance with another sector, but being innovative and doing work out beyond our walls: certainly one of our core values as a community. Our business extends way beyond the walls of the centre that we work in. This afforded us the opportunity to help the mentally ill and address some of the challenges of stigma that exist today.

Mr. Dave Hookway: Good afternoon, ladies and gentlemen. Thank you very much for having us here today. My name is Dave Hookway. I'm a police officer with Durham regional police. I'm just going to briefly speak to the policing aspect of this.

I became involved in about October 2007, when Wendy and Marjory put on a course for our service. I became the mental health response officer, which is an officer who is on the front lines and has a little bit more training than the regular officer on the road. This was all brought about by a very simple phone call from our service to Wendy in regard to putting something together, hopefully to get a collaboration, a partnership, together with our mental health folks, which obviously happened. We've had great support from our executive leadership—our chief, deputies and downward. We've been allowed to put this product together. I think, when you see it, you'll be very pleased with it. It is a collaborative effort. We are a team. We do these presentations as a team.

Initially, I think, there was some apprehension between the police and the mental health services, which

is what happens quite often. Our main goal, though, for both of us, is to get people who have mental health issues the help that they require. All these scenarios are based on real-life events that happened to our officers. I'm not the only officer who participated in this; I was just lucky enough to be involved in it a little bit further. We wrote the scripts as they happened. It was a great learning experience for everybody involved: ourselves as the police and obviously for the folks from the mental health services.

They're easy to use. What we have done in Durham regional police is that we have put them into our e-learning program. Every officer on the road—I believe it was last year—had to go through this entire thing and complete it successfully. We like to do a debrief with these; this is not a stand-alone training package. As the police, we do other training throughout the year. We found that people have said that a debrief would be very important when we show and do these. It is currently being used. It's free, so that's always a good selling point for folks in the policing services and any other place. We currently have given this to several police services, and I believe some RCMP officers in British Columbia. We have some people in the east coast, Nova Scotia. Is that correct?

Ms. Wendy Stanyon: The Nova Scotia Department of Justice has the links and is using them in their education for officers in the province.

Mr. Dave Hookway: York Regional Police, I believe, and the Toronto police have a copy of this, and some OPP detachments are also using it. That's basically the policing aspect of it.

I'm going to hand you over to Erin Banit, and she can go through one of the scenarios with you. Hopefully, you'll enjoy what you see.

Ms. Erin Banit: Thanks. My name is Erin Banit, and I'm a multimedia specialist in the Innovation Centre at Durham College and UOIT.

I'm going to give you a demo of one of our scenarios. We have four different scenarios. The one that we're going to look at today is our suicidal scenario.

Audio-visual presentation.

Ms. Erin Banit: Each of the simulations starts with a dispatch call. All of our scenarios are based on real calls that have actually happened, and officers have identified them to us as ones that they would like to learn more about or that they thought other officers would benefit from learning more from.

After the officer listens to the dispatch call, they can use the navigation on the left to go through the simulation in whichever order they want. They can go back to sections if they want, or they can use the navigation on each screen to go through it in a more guided fashion.

Audio-visual presentation.

Ms. Erin Banit: I'm going to mute the voice narration for the sake of the presentation, but I did want you to see that it is actually there. There is voice narration throughout the entire simulation just to help guide the officers through it.

In our fact-gathering section—in this one in particular, we have three different areas. The first one is risk factors. When we met with police officers when we were designing the simulation, something they said they often do, or they usually do, when they're on their way to a call is run through all the risk factors in their head or they talk about it with their partner. So we've listed all of the risk factors for this call, and we've asked them to identify which ones would be relevant or might be relevant in a mental health encounter.

Another section we have in the fact-gathering area is a place where they can gather information. In this particular scenario, the officers were able to have a conversation with the subject's parents before having their main encounter with the subject. So we've broken it down into different sections. The officers can pick and choose what they'd like to find out more information about.

For example, details of incident:

Audio-visual presentation.

Ms. Erin Banit: I'm going to stop that, but that one was for what happened.

Another example is: Has he ever done this type of thing before?

Audio-visual presentation.

Ms. Erin Banit: So there are several different areas where the officers can pick and choose what they would like to find out more information about from the parents before they have that main encounter with the subject.

The other section in our fact gathering is mental illness. This is an area where there are various activities that the officers can complete to help them gather additional knowledge on the specific mental illness being dealt with in this scenario.

We have things like multiple choice, we have some drag-and-drop—this one, for example: "Which four statements below are facts about suicide?" The first one says, "Young people and seniors are least likely to consider suicide." I thought that this was a fact; however, it's a myth. Individuals between the ages of 16 to 24 and over the age of 65 have the highest rates of suicide. That one I found very surprising.

In the top right-hand corner, you can see that there's a link for psychosis. If the officer clicks on this, they are given a definition for psychosis. There's also a link to visit the library, where they can find out more information on psychosis, and there's a wide range of other information that they can get in there as well. We have these links throughout all of our simulations because there was so much information that we wanted to make available to the officers, but we didn't want it to be too overwhelming to them. This way, they can choose if they want to find out more information about that; they can click on the links and go in there.

1740

I think, for the sake of time, I'll skip through the other activities we have here. There's some more drag-and-drop multiple choice.

I'm going to jump to the next section, which is preliminary events. This particular scenario has some things

that happened before the officers had their main encounter with the subject. One of them was that one of the officers was at the girlfriend's house talking to her, and she received a text message from the subject. So we have a question around that.

Another preliminary event is a cellphone conversation which took place; the officers were able to call the subject on his cellphone. We have a little activity here, and we have asked the officers to choose how they would open up that cellphone conversation. We give them two choices. The first one is, "It's Officer Mike. I need to know where you are. I'm concerned for you." The second choice is, "Hi, Justin. It's Officer Mike. I would like to help you." I'm going to choose the first one.

Audio-visual presentation.

Ms. Erin Banit: We hear the response, and that's obviously not what we were looking for. The reason why I actually choose this one is because of the language that's in it. When we were first working on the project, there were some people who were hesitant about having that type of language in it, but it was something that, having the officers there helping us build them—they said, "You have to have that language in for it to be realistic. You can't substitute other stuff in."

I'm going to move on now to our main encounter, and this is where the bulk of our simulation really takes place. I'm just going to jump over to a flow diagram, just to give you an idea of what's happening in the background. When we go into it, it's not always obvious how many choices and pathways there are. With our main encounter, it involves conditional logic, where the officers watch a short video clip, and then they're given a couple of choices about how they might proceed. The officer decides which choice they would make, and then they're able to see how that scenario might have evolved based on the choice that they made. Then they're given feedback on that as well.

You can see that there are a number of different pathways. Down at the bottom, there are some little bubbles, and that shows the different outcomes. The least preferred outcome is self-injury. The most preferred outcome is the subject puts down the knife and agrees to continue discussion in a controlled environment.

I just wanted to show you that before we actually get into it so that you can see what's happening in the background, and all of the possibilities that there are.

Audio-visual presentation.

Ms. Erin Banit: From here, the officers are asked, "Which approach would you take? Would you maintain dialogue with a focus on the knife or maintain dialogue with a focus on Justin's feelings?" I'm going to choose to focus on the knife.

Audio-visual presentation.

Ms. Erin Banit: You can see that we have the resulting video clip of how that scenario might have evolved and the feedback on the scenario and the choice that they made.

From here, they're asked, "Keeping in mind Justin's increasing level of agitation, choose from the following

responses: Attempt to minimize the risk by engaging with Justin and explaining why your gun is drawn or continue to focus on containing the situation by getting Justin to drop the knife." I'm going to continue to try to get him to drop the knife.

Audio-visual presentation.

Ms. Erin Banit: Obviously this is the least-preferred outcome, resulting in self-injury. The officer is told that they've reached the end of this pathway and they should press "continue" to start at the beginning and go through and make alternate choices.

We'll go through again, and this time I'll make choices to bring us out at one of the preferred outcomes.

Audio-visual presentation.

Ms. Erin Banit: I'm going to pause that because we've seen that already. I'm going to press "continue," and this time, I'm going to focus on Justin's feelings.

Audio-visual presentation.

Ms. Erin Banit: From here, "Keeping in mind Justin's increasing level of agitation, choose from the following responses: Officer will holster his firearm or officer will keep his firearm drawn." I'm going to choose to holster my firearm.

Audio-visual presentation.

Ms. Erin Banit: From here, the officer is asked, "What is the best option given that the officer successfully negotiated and de-escalated the situation—to apprehend under the MHA or refer to community resources?" I'm going to choose "apprehend."

Audio-visual presentation.

Ms. Erin Banit: From here, the officer is directed to the conclusion, where they are given a list of key concepts and helpful strategies and some "Did you know?" facts.

That gives you an overview of one of our scenarios. Like I said, we have three other ones created on top of this, but I won't take you through all of those because I think we're out of time anyway.

1750

The Chair (Mr. Kevin Daniel Flynn): I think the bell is going to ring any second.

Go ahead, Ms. Jones.

Ms. Sylvia Jones: Thank you for coming in and showing us that. You mentioned that a number of other police services have tapped into it. How long have you had this in Durham?

Ms. Wendy Stanyon: About 18 months, and we've given the files to many police services which then have put them on their own servers so the police officers in their area can access them.

Ms. Sylvia Jones: How do you decide which front-line officers have access to or are trained in this scenario?

Ms. Wendy Stanyon: For Durham region, they've made it mandatory training, so all Durham region officers have to go through this. Many of the other police services are looking at how to incorporate it: many OPP detachments; Toronto Police Service was looking at how they were going to incorporate it; York region. Many of them are putting them into their own e-learning, and we've had

requests to build more. We're consistently looking for funding because the response we have is that it's working with a variety of police forces. I guess we could say that we haven't had anywhere that has given us negative feedback. It has really continued to be extremely positive.

Ms. Sylvia Jones: The training itself: How long is that for individual officers? Is it a half-day?

Ms. Wendy Stanyon: When we were actually researching them and we had officers doing all four of them, they were probably on them for anywhere from half an hour—I would say?

Mr. Dave Hookway: I would say half an hour or 40 minutes, something like that.

Mr. Chris Hinton: It depended. They're very engaging; if you go down one avenue, you can go quickly, but typically you find that people want to go through all different avenues. By the way, my name is Chris Hinton. I'm director of the Innovation Centre, and I was also a partner in the research. We got funding from the Canadian Council on Learning to verify that these simulations were effective, that they engaged the officers and that they helped them in decision-making and confidence. Indeed, our research verified that these are as effective as face-to-face. It has been very positive.

The Chair (Mr. Kevin Daniel Flynn): The bells have just started ringing. I'm not sure if it's a five-minute or a 10-minute bell. If it's a five-minute bell, we need to go and come back and ask you questions, if you don't mind excusing us for about 10 minutes.

Mr. Jeff Leal: It's a 10-minute bell.

The Chair (Mr. Kevin Daniel Flynn): It's a 10-minute bell. Okay, why don't we try one question, then? Jeff?

Mr. Jeff Leal: When you're faced with a situation, and you provide the simulation, do you use the federal gun registry and see if guns may be present?

Mr. Dave Hookway: For an officer going to a call, dispatch would generally do checks on CPIC, that type of thing. I can't 100% say that that is something they would do. I believe that they might. Our dispatchers certainly try to get as much information as possible for us for that particular location.

The Chair (Mr. Kevin Daniel Flynn): France.

M^{me} France Gélinas: I will try to phrase this as delicately as I can. We all know that there's a lot of stigma surrounding mental health. We all know that a lot of seasoned officers have dealt with a lot of people with mental illness and sometimes have developed views that are very stigmatized of people with mental illness.

I'll backtrack a little bit and say that in a previous life I was the executive director of the community health centre in my community. We taught suicide prevention to police officers and a lot of other people.

To make it mandatory training, how do you make sure that your officers are at a time and place in their career

where they are open to training? Sitting for half an hour in front of a little video clicking a mouse: Anybody can do this. Learning is a completely different aspect, whether the training is done with a human being or through a very well-laid-out program. Just your comments on that.

Ms. Wendy Stanyon: I'd just like to respond. I think one of the ways that we developed these was by including the officers. What we found was that most of the officers even in Durham region have an invested interest in these. They know how they were developed. They know that police were front and centre in developing them. It's colleagues who are in them.

We've had a similar response from other police services who are using them: There's an invested interest. It's not mental health experts coming to tell police what their job is. I think sometimes that's what happens when we partner: We want to tell other people what we know and what we think they should do.

We started by saying, "You tell us what your issues are. You help us build education for you as officers."

I would say that we have a lot of good support, and they're invested. This is their educational product that they helped to develop.

Ms. Marjory Whitehouse: If I could add too: The feedback that we got from officers is that you can fail and make a mistake without any dangerous things happening, without embarrassing yourself.

What we did learn through this collaboration is that a lot of what we're trying to promote in mental health, to reduce stigma, is counterintuitive to what officers are taught in terms of responding to crisis situations. We've been challenged before in mental health places, saying, "My goodness, the person's suicidal. Why would the officers draw a gun?" "The person was armed." So we have to interface different use of force with mental health aspects in terms of managing this.

That grassroots level, as mental health people trying to critique the dialogue that was suitable for police officers to be comfortable enough to use it, made it more real, made it more believable. The feedback we got in terms of the research was that the face-to-face learning and these electronic video learning interactive tools were equally as good. The research gave us information too that officers were learning as a result of using them.

The Chair (Mr. Kevin Daniel Flynn): I'm going to have to cut you off right there. Do members of the committee have more questions? If we have more questions, then we should come back. If we don't have more questions, then I should thank the delegates for being here.

Interjections.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much. That was wonderful. Congratulations.

The committee adjourned at 1756.

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Wednesday 28 April 2010

Journal des débats (Hansard)

Mercredi 28 avril 2010

Select Committee on Mental Health and Addictions

**Mental health
and addictions strategy**

Comité spécial de la santé mentale et des dépendances

**Stratégie sur la santé mentale
et les dépendances**

Chair: Kevin Daniel Flynn
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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

SELECT COMMITTEE ON
MENTAL HEALTH AND ADDICTIONSCOMITÉ SPÉCIAL DE LA SANTÉ
MENTALE ET DES DÉPENDANCES

Wednesday 28 April 2010

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*The committee met at 1555 in committee room 1.*MENTAL HEALTH
AND ADDICTIONS STRATEGY

LHIN COLLABORATIVE

The Chair (Mr. Kevin Daniel Flynn): Sorry to hold you up. One member, in particular, has been asking about the LHINs, and I was hoping he would be here today, but he must be otherwise—that was Bas Balkissoon from Scarborough, who has been talking about where the LHINs fit into this throughout the committee proceedings. He may have had some questions for you that maybe the others don't, but I'm sure he can correspond with you.

I'm just going to turn it over to you. Thank you for coming. For the other members, Bill is the lead in the Mississauga LHIN but is also working with the collaborative, and this is a presentation actually from the collaborative. Is that right?

Mr. Bill MacLeod: I can clarify that. Thank you very much for meeting this afternoon. It's such a nice day out there, and I appreciate the time to come and talk to you about mental health and addictions.

I'm going to introduce my associate Angela Jacobs. She will be making part of the presentation, as well, on a particular area that we've been investing dollars in in the Mississauga Halton LHIN.

I'm here representing all of the LHIN CEOs. We had a discussion amongst ourselves and agreed that I could come and try to do the best I could to represent all 14 of the LHINs. I'm also chair of the LHIN Collaborative, which is a group that has been put together. It represents leadership from the LHINs but also leadership from the various sectors of the field. Six sectors, plus public health, primary care and Cancer Care Ontario, are represented with the LHIN Collaborative, and I can talk a little bit more about that.

Then I want to give you a bit of an overview of what we've been able to do at Mississauga Halton, because it's a little bit easier for me to speak about some of the specifics that we've been doing in mental health and addictions in our own LHIN, and that's this document here; that's a handout.

Then Angela will take you through a presentation of a new initiative that we're just launching—in fact, early

next week—that will be a further investment of funding into expanding the services of mental health and addictions.

I know we've got 45 minutes. I'm going to try to go fairly quickly because I know that's to include time for questions as well.

First of all, on behalf of all of the LHINs, I think we're quite appreciative of the time with the committee to talk about mental health and addictions and talk about some of the things that we see coming down the road and how the system could be improved. I believe that's very much what the committee is also trying to understand: what the issues are and how to get at improving those.

While all LHINs are inherently different from a geographic and from the population that geography contains in terms of the distribution, the makeup of the population, the age distribution, all kinds of different characteristics, and that really shows the uniqueness of our province, what was common across all LHINs was that when we went out to do our integrated health system planning—which was the first order of business for LHINs when they were created: to go out and talk to the community, engage the community and understand what issues the community sees—universally we got back the common theme of mental health and addictions. It's an area that consistently, wherever you are across the province, is felt by citizens to need attention and improvement.

The common themes that we heard—again, I'm going to go quickly because I'm sure you've heard all of these by now, but I do feel it's important to reiterate some of them.

Navigating the system is tough. People, when you go and talk to them, find it very difficult to find their way through the mental health and addictions systems. In response to that, many of the LHINs have started to implement the so-called “no wrong door” approach to mental health. I think you've probably heard about that, but we can talk about some of that later.

There's also this need for significant interaction between the mental health sector and all sorts of other sectors, whether it's the primary care sector—and I know you received a presentation from the Canadian Mental Health Association and the Ontario association of community mental health and addictions programs.

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When those sectors—and I shamelessly put in a plug for the LHINs at this point—all dealt with the Ministry of

Health as sectors, you could often get all the way up to the Deputy Minister of Health before there was a cross-over manager; in other words, the way the community health branch moved up and reported to an assistant deputy minister or director and then it was really the deputy minister's job to actually put these things together, and it really isn't his job.

So that's where the LHINs come into their prime, because the folks in the LHIN—and we're a small group. The Ministry of Health has 4,000 employees. I think they're down from where they used to be, but it's still a very large organization. My organization is small. I have less than 30 staff. The folks who are dealing with housing, who are dealing with mental health and addictions, who are dealing with community support services, who are dealing with the hospital side of things, and the ones who are dealing with primary care, if I threw a bucket of water in the air, all of them would get wet, because they sit that close together. So that's the way in which we're able to bring that integration at the sector level, at the LHIN level. I think that's an important thing to remember, and I'm going to come back to that.

One of the other areas that was a common theme was the need for a common language and tools for measuring outcomes. There's a broad variety of ways in which people think that the system performs and a broad variety of ways in which the system is measured right now, and we need to bring that down to a common way of approaching that.

Universally, we found that agencies themselves were saying, "You know what? The way we've been funded in the past, there are significant efficiencies that we can gain if you can bring about some back office integration, some co-location of our services and some shared training and development within our sector." Those were themes, again, that universally, regardless of the underlying population, the LHINs found as they went out and consulted with citizens.

Each LHIN—again, I want to make sure you appreciate it. Because it is a priority, each LHIN is looking at what resources they've got and how to bring those resources to bear on this problem. So while there aren't new resources necessarily all the time in particular areas, we're finding ways to use the existing resources to bring about addressing those themes. I'm here to say that each LHIN is making progress, very definitely.

In addition to the common themes that we came across through our integrated health services plans, we agreed that with the LHIN Collaborative, in our partnership with the agencies, we would work on this problem collectively as well. So we've identified a lady by the name of Marion Emo, who used to be the executive director of one of the CCACs—no, sorry; I'm wrong. She actually was the executive director of one of the district health councils. She's taking the lead in this on behalf of the LHIN Collaborative. We're assembling a group of representatives from primary care, the mental health sector itself, and the community support services sector, as well as representation from hospitals, to look at how to

make that collaborative work well, primarily around the area of sharing best practice. One of the great things about our system is that because we've created areas of devolution of responsibility, what you're finding are significant attempts to find new ways of doing things, new approaches and innovation, and one of the things that's good is that you find better ways of doing things. Where it's bad is if you don't have a mechanism to rapidly share those best practices. So one of the responsibilities of LHINC, the LHIN Collaborative, is to rapidly share best practices. That's one of the key themes that this group will be working on.

I'm going to shift from there, talking at the provincial level, to talking a little bit about what we've been able to do at Mississauga Halton. I'd ask you to turn to the hand-out. Again, very quickly, I'm just going to run you through some of the accomplishments. I apologize that the pages aren't numbered, but it's three quarters of the way through the slide deck, and it says, "Accomplishments for 2009-10."

Again, some of these are fairly straightforward: some of the community engagement activities that we've been able to take on; the education programs that we've been able to put in place that allow all of the agencies in our LHIN to participate and enjoy an education program that none of them would have been able to put on individually.

We're working with the ministry to look at MIS definitions, to make sure that when people are calling something a visit, a clinic involvement or whatever it is that we're identifying as the unit of measure, there is a way of consistently looking at that across all agencies. It's a significant problem now because there are not universal ways in which these are defined.

We've gathered and ranked quality indicators, which was an important piece of work. We didn't really invent much, but it was bringing the players together to say, "How do you measure quality? Is there a common way that we can look at how quality should be measured across all agencies?"

Again, we've been spending a lot of time looking at access to services, and Angela is going to talk to you about a significant gap we found and what we've been able to do about that.

We've established a collaborative table for both youth and adults. There's a real disconnect around youth with mental health and addictions issues. The fact that we've actually got a Ministry of Children and Youth Services also adds to that because, again, you've now not just got a Ministry of Health, but you've got another ministry that's involved.

On that topic, it's also important to understand, as I'm sure you do, that you've got the ministry of justice that's involved and you've got a range of other ministries that are also involved in the whole area of mental health and addictions, how they are brought to bear on this problem and how the LHINs are able to work across all of those ministries to bring the local resources together to deal with these problems.

So that's, very quickly, some of the things we've been doing. I didn't want to cover all of them because, again, I recognize that our time is a bit short.

I'm going to turn it over to Angela right now to fairly quickly walk you through a specific program that we found and one that we're going to be launching, as I say, this month.

Ms. Angela Jacobs: I did provide a handout, and I'm sorry; it's probably a little bit of an eye chart because I put three on one page.

Anyway, I just wanted to talk to you about this initiative that we are launching next week. It's called Strengthening Community Supports for Concurrent Disorders. It came about as a result of a report that came out of SEEI—and you'll see that in the package that Bill provided as well—in that we saw that our LHIN, which is LHIN number 6, on the far right, was the only LHIN that showed an increase in early returns for mental health and addictions clients to the ER. This was, I think, from 2006 to 2007. We formed a working group and we decided to take a look at why we were such an anomaly. So we set up a group of health care service providers from our LHIN, mental health and addictions, and some data people, and we started to go into the data itself. We showed that we actually had a three-year increase in return rates for mental health and addiction clients to our ER; 23% of them were repeat visits within 30 days. Most of them were related to substance abuse; 23% were related to depression and anxiety. Some 32% were what we call young people—we go all the way up to age 30, actually, ages 17 to 30.

Of those, only 29% were admitted to hospital, which shows that, again, the emergency department is not a good place for these patients. We wanted to look at how we can actually help that.

So our working group came up with 10 strategies, and the top three to address this particular population of substance abuse combined with mental health: We needed to look at a bridging program from the ED to community services, we didn't have enough capacity in our LHIN around chemical withdrawal, and we needed intensive case management for people with concurrent disorders: those clients who have a substance abuse as well as a mental health issue.

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This is our system as it kind of looks now. There are a lot of silos in the system. As a client comes out of the ED, they're discharged. They may be referred to a service, but they could take weeks to get to that service. Again, that's one of the issues why they end up back in the ED. Even if they are able to find a service and need to go through chemical withdrawal, there's usually a long wait for that. Then, if they go through the chemical withdrawal system, there's a wait of up to 12 to 28 weeks for referral to case management. So, at any point in that system, that client could be on their own—chances of a relapse are very high—and end up back in the ED.

What we looked at, and what we're developing, is this continuum of service to support the client right through

the continuum they need for getting help so they're fully supported and we reduce relapse rates and, hopefully, repeat visits to ED. I'll tell you how this program is working.

We've got a LHIN-wide program, again, not specifically around regions—Halton region versus Mississauga. This is a LHIN-wide program. We're investing in three supports: crisis supports, chemical withdrawal management and enhanced concurrent disorder case management. So they're going to create seamless, timely support for these clients who have addictions and/or concurrent disorders as they go through the system.

CMHA Halton is actually our program lead, and they are working with a lot of our other HSPs in our LHIN, so we're going to reduce the number of different referral forms—we're actually going to use this as a way to integrate our system. Not only is this new program going to be integrated into all of our existing system itself, we're going to make this as seamless as possible because all the handoffs we have between providers are where there could be issues. They're going to respond to urgent referrals. There's going to be a commitment to actually prioritize these clients who come out of the ER or who come out of in-patient units. So they have been treated—they've had a call for help—and you can actually work with them immediately rather than giving them time to think about it or relapse.

With the crisis management, it is the community agencies that will be providing this, but they will get a call from our EDs that someone has shown up in the ED with these particular characteristics. They will go into the ED and support that person through the ED experience, if required, and then help them to either connect with other supports or support them as required until they can meet with case management. Again, this will provide the safety support needed, if any, during a period of probably increased suicide rates.

Now, if required and if needed, they can go through chemical withdrawal management, which is not the typical withdrawal management you think of; this now is actually best practices community withdrawal. It can be done in their homes; it can be done in the offices in evening hours. It is actually taking the service to the clients, as required, and reduces the risk of relapse. But while they're in this program and even when they come out, there will be associated concurrent disorder case managers who will support this client until they actually connect directly to longer term case management to keep them clean, sober etc.

We're enhancing case management around concurrent disorders as well. There are pockets in our LHIN that are actually lacking in some services, so we're actually targeting this geographically as well to provide supports. These case managers will accept urgent referrals from the ED, because again you don't want to have a 28-week wait period for someone who has shown up in the ED seeking help. We're hoping to improve the flow of the system for these clients and to strengthen linkages with existing community programs, as Bill mentioned.

We have services that provide help to many of these clients in our LHIN, but the linkages aren't there. Again, you need this navigator, which is what the case management will do. We've got COAST teams, we've got safe beds, crisis beds, ACT teams, intensive case management, connect with primary care physicians, seniors, youth services—whatever other community services some of these clients might need.

This is just a bit of a pictorial illustration of what this system will do. We've got our three hospitals in our LHIN with their emergency departments. One of our providers will have two concurrent case managers and the other will have another concurrent case manager. These are addiction councillors, case managers who will actually go into the ED. Then there's withdrawal management to providers. This, of course, is going to be LHIN-wide—we've had withdrawal management in the Mississauga portion of our LHIN but not in the Halton portion, and then longer-term case management for concurrent disorders as well as connecting with all the services below. In total, we are investing \$1.5 million for 17 new full-time-equivalent staff.

Now, we're big on performance and accountability, so we would like to see about an 80% reduction in early return ED visits—those that are less than 30 days—for substance abuse and concurrent disorder clients, and a 10% reduction in new visits to the ED for these particular types of clients. We expect to see a reduced stay in our hospitals as well. Sometimes they have a difficult time discharging in-patients because there's nowhere for them to go because, again, the wait times for some of our community services are very long. Hopefully, we will increase client satisfaction and experience and provide increased access to concurrent disorders in our LHIN. That's it.

Mr. Bill MacLeod: Thanks, Angela.

I thought I'd leave you with a couple of thoughts. One really ties exactly in to this, in that one of the roles that I believe the LHINs can play remarkably well is integration across sectors and bringing all forms of health providers together to integrate services, so that the patient/client sees this as a seamless service that's delivered at the local level. That includes primary care. One of the things we struggle with at times is that people say, although it's patently not true, because the LHIN act doesn't preclude us from being involved in primary care, "You don't have anything to do with primary care." Just that thought often forms a barrier. So one of the things we think is quite important is that there is, in fact, a reinforcement of the LHINs' role in primary care, coordinating best practices in primary care and officially linking primary care with the rest of the system.

Our LHIN is one that has a significant number of hospital-based primary care physicians, but even in our LHIN, only 50% of primary care physicians are actually attached to hospitals. So you have 50% of the primary care physicians out there, virtually unattached to the system, and I think it's important that the LHIN can form that integrating or attaching kind of role from the primary care system to the rest of the system.

The second thought is about the need for a provincial entity—I use the word "entity" in the sense of not necessarily an agency but potentially an agency—to take a leadership role to look at what are clinical best practices; to look at clinical performance and outcomes, and how it's measured, how it varies from region to region; where to set benchmarks in terms of requirements for improvement; to develop a regional presence that works with the LHINs and brings that clinical expertise to work with the LHINs and use the LHINs' planning authority, funding authority and integration authority to achieve that true integration of the system—but predominantly bring the evidence.

One of the agencies we're working very closely with is Cancer Care Ontario. I think you're aware of their role and how they have established regional presence. The LHINs work very closely with that regional presence, and as CCO continues to roll out their role in chronic kidney disease, the same approach is being taken. We're working with the clinical experts, but implementing that at the local level. I'm not suggesting that Cancer Care Ontario should become the agency, but I am suggesting that we should look at that model and look at a provincial entity that does bring that kind of expertise, that evidence base and the ability to pull together best practices and data to inform clinical decision-making at that regional level.

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With that, I'm going to end, and open up for questions for either Angela or myself. Again, I express my thanks for the opportunity to present to you.

The Chair (Mr. Kevin Daniel Flynn): Thanks, Bill. Just for the edification of us all, your definition of a young person is anybody from 17 to 30; is that right?

Mr. Bill MacLeod: We've been looking at children and youth, and then young adults, and we're also trying to look at the mental health issues of our seniors. It's a very significant problem. The system is often not well designed to deal with mental health issues, and unfortunately, the behavioural issues that arise in a senior with mental health problems start to push them into institutionalization much too quickly—

The Chair (Mr. Kevin Daniel Flynn): I was thinking about the other end of the age spectrum, though. If I show up and I'm 18 or 19, you seem to have a plan for me. You've got something you'd do with me based on this flow chart. If I was a mom or a dad and I showed up with my 12-year-old who was going through anxiety or depression, somebody else funds that then? Is that MCYS? Do you act differently then? Do you do something differently? Does that cause confusion or problems for you?

Ms. Angela Jacobs: Actually, we call a youth in our system, I think, 16 or above. But anyone who shows up to a hospital—whatever age—obviously is treated.

We're just launching this and we need to see what the need is around this, because, again, to take somebody who's 15 into some of these services that we fund, community mental health and addiction services—their mandate is not necessarily those younger than 16.

The Chair (Mr. Kevin Daniel Flynn): But do you have a plan for them?

Ms. Angela Jacobs: We have a task group that is working in conjunction with MCYS around the transitional-age youth.

The Chair (Mr. Kevin Daniel Flynn): Okay, because we're getting a lot of—I think the first group we heard from was Parents for Children's Mental Health, and since then, there has been some criticism levelled at the system in general about how we're not paying attention to children's mental health issues.

We've had discussions as a group between ourselves about how the one is funded by the Ministry of Health and the one is funded MCYS. I guess it's a little early to tell if that's causing any problems for the LHINs?

Mr. Bill MacLeod: It's almost a mental model issue. While the LHINs are truly provincial agencies, our boards are appointed by the Legislature through the Public Appointments Secretariat process. We're also seen as somehow creatures of the Ministry of Health, so it's often difficult for us to get other ministries to see that, "Oh, yes, you're a crown agency. We can work with you at the local level."

That's not a problem. We're quite open to that, but it's not always seen as open on the other side, and that partly has to do with this notion of health gobbling things up. The reason why I think we have a Ministry of Health Promotion is that we're trying to not have health be defined as everything, and therefore, every ministry is somehow under the jurisdiction of the Ministry of Health. There is this kind of creative tension, I guess, going on, and we're finding that when we get to meet with folks face to face, they understand the issue and understand we can be helpful and not trying to take over their responsibility.

The Chair (Mr. Kevin Daniel Flynn): Questions? Christine.

Mrs. Christine Elliott: My question was really a variation on that because the transitions are being presented to us as being quite problematic. Would it be fair to say that it doesn't make your job any easier, the fact that you don't have specific responsibility for children and youth in order to be able to plan accordingly? You're sort of dependent on those groups to come to the table and offer their services to you?

Mr. Bill MacLeod: Again, it's a little bit variable from LHIN to LHIN in terms of who the players are and that kind of thing. But you're right, when we're the funder and we ask people to come to a table and help us plan, most people show up. It's sort of good politics to come and keep the funder happy. But for those that we don't fund, we still have a planning role and responsibility. It's a little tougher to get them to fully engage with us at times.

Mrs. Christine Elliott: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Jeff, then Liz, then Maria.

Mr. Jeff Leal: Thanks very much. I apologize for coming in a bit late.

It seems to me your LHIN has certainly picked up on the mental health issue. How did that come about? I mean, board members—I know there is the overall mandate of LHINs in the province of Ontario. But just quickly reviewing your slide deck, your particular LHIN seems to have picked up on the mental health issue and forged forward to bring about integrated services and case management. How did that evolve for your particular LHIN?

Mr. Bill MacLeod: I think the early part of my presentation indicated that in fact all LHINs had identified mental health and addiction as an important issue. If you look at—

Mr. Jeff Leal: It just seems to me some are more advanced than others.

Mr. Bill MacLeod: Only because I think we're presenting today and I'm a little more comfortable presenting what we're doing than, say, Waterloo Wellington, which I know is doing great things as well. Eric St. Clair is actively working in this. North Simcoe Muskoka, again, is looking at the co-location issue and the common hosting approach to bring and integrate services.

I want to kind of disabuse you of the notion that we're somehow the only folks doing this. I'm a type A personality, so I would hope we're doing it better or just as well as anyone else in the province—probably better—

Mr. Jeff Leal: I wanted to give you that opportunity.

Mr. Bill MacLeod: So if it turns out that you find we are leaders, I'm glad that we are leaders because that's what I would like to see Mississauga Halton be.

We also have a commitment to share best practices, and that's the notion of the LHIN Collaborative and why all LHINs have committed jointly to funding it and why the ministry has committed to put—about half the funding for LHINC comes from the Ministry of Health itself, so that we can see what works well and then very rapidly adopt that.

The analogy we use is the very best companies in the world allow local creativity and innovation and experimentation, but once they find something that works, then they adopt this rapid-cycle-adoption approach and very quickly bring in those things that work best. I use that as a way to come back full circle to say that's why we need a provincial entity, that's why we need somebody who is also involved in looking at this, bringing the clinical expertise the way Cancer Care Ontario brings clinical expertise to the system as a whole, to the province as a whole.

Mr. Jeff Leal: So you see the LHINs as a pretty good platform to have integration and provide case management etc. in this field?

Mr. Bill MacLeod: Absolutely. I had personal career opportunities in a whole lot of different places but I really saw LHINs as a very valuable role for improving the system and integrating it at the local level.

Mr. Jeff Leal: So, Bill, where were you before you became the chief executive officer at the Mississauga Halton LHIN?

Mr. Bill MacLeod: I was in Hamilton, working first as the interim president and CEO, when they were under supervision—

Mr. Jeff Leal: Oh, of the hospital in Hamilton?

Mr. Bill MacLeod: Yes. The supervisor brought me in, and then the CEO, when we recruited a permanent CEO, asked me to stay and work on some special projects. What I thought was going to be a two-year stint turned out to be seven. My last role there was vice-president, research and development, for Hamilton Health Sciences.

Mr. Jeff Leal: Angela, where were you before? I'm always interested in background, you know, because LHINs are a new entity.

Ms. Angela Jacobs: Right. Actually, I don't come from a health care background at all.

Mr. Jeff Leal: Okay.

Ms. Angela Jacobs: I actually have process improvement, a six sigma black belt consulting and the automotive industry.

Mr. Jeff Leal: Interesting. Okay, very good. Thanks for your responses. I appreciate that.

The Chair (Mr. Kevin Daniel Flynn): Thanks, Jeff. Liz?

Mrs. Liz Sandals: All sorts of questions occur to me here, so I'll just start going through them. And congratulations on putting a process together.

You've got here that CMHA Halton is the program lead, and that's true in Mississauga as well as Halton?

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Mr. Bill MacLeod: Yes. One of the criterion we established was that if we were going to fund a new program that it had to be for the whole of the LHIN. One of the agencies could take the lead in that, but they had to see it as serving not their traditional catchment area, but in fact working with the other agencies to serve all of the people in the LHIN.

Mrs. Liz Sandals: So when you say they've got the lead, what does that mean in practical terms?

Mr. Bill MacLeod: That they will work with all of the providers that were identified—and I apologize; some of the names—we're great for all these acronyms in health care. PAARC, for example, is one of the providers on that slide deck. Adapt is another provider. So CMHA Halton will work with all of those providers to make sure that this is a seamless integrated program across the whole LHIN.

Mrs. Liz Sandals: So you've still got the pre-existing providers.

Mr. Bill MacLeod: Yes.

Mrs. Liz Sandals: But there's more coordination than there used to be.

Mr. Bill MacLeod: Absolutely.

Ms. Angela Jacobs: CMHA Halton has primary responsibility and accountability for the entire program, and they have memorandums of understanding with each of our providers around their accountabilities. So they are managing the entire program and all of the integration.

Mrs. Liz Sandals: At one point, there is a reference here to chemical withdrawal. I'm assuming that that means both drug and alcohol?

Ms. Angela Jacobs: Yes.

Mrs. Liz Sandals: So when you get the referral to this withdrawal program—it was previously a community withdrawal program, not a residential withdrawal program.

Ms. Angela Jacobs: It was always a community withdrawal program, but there was not the capacity to have a LHIN-wide program. It only served residents of Mississauga, and there was a long waiting list.

Mrs. Liz Sandals: So that program has been expanded. There are a lot more workers, a lot more places where you can physically go to meet with your case-worker or whatever?

Ms. Angela Jacobs: Yes.

Mrs. Liz Sandals: That particular service has expanded. Were there other services that shrank, or was it just that there was only one service and it didn't cover the whole LHIN?

Ms. Angela Jacobs: That was the case: one service.

Mrs. Liz Sandals: Okay. And then you go to current case management. Who's doing the case management?

Ms. Angela Jacobs: We've got three providers. CMHA Halton is doing some of it; Trillium Health Centre, in their community mental health program, is doing some of it; and Adapt is also doing some of it.

Mrs. Liz Sandals: And were those three organizations—same question as before—previously doing case management?

Ms. Angela Jacobs: Yes, they were.

Mrs. Liz Sandals: And were there other organizations that were previously doing case management and no longer do case management?

Ms. Angela Jacobs: No. This is purely new funding, new investments. We've just increased the existing capacity in case management.

Mrs. Liz Sandals: So you say that you've broadened the catchment area, so to speak.

Ms. Angela Jacobs: Right.

Mr. Bill MacLeod: And ensured that it is universal across the whole of the geography, so that there weren't gaps occurring. One of the problems with the historical system is that various entities would come into being and get funded, but it was almost a patchwork quilt with a lot of holes in it.

Mrs. Liz Sandals: In fact, that has been one—the reason I'm sort of picking away at this is because one of the concerns that we have had is that, particularly with children's mental health but with adults as well, you get this whole host of agencies which may have overlapping responsibilities. So, for example, with something like case management or wait-lists or whatever, you may have three or four different agencies trying to manage the same individuals, and it's not actually clear that anybody can see the big picture, either about one individual or about the whole system, because nobody is actually

running the show; everybody is just seeing their own little piece of the show. That's what I'm trying to get a sense of. Through the way you've organized this, have you actually gotten rid of this sort of overlapping and nobody seeing the big picture?

Mr. Bill MacLeod: I don't think we've fixed it entirely, but we're moving a step closer to having that truly fully integrated system. I think the idea of having a regional entity that has that full responsibility and brings the clinical expertise as well—that's one of the things that the LHINs struggle with. Angela's great with the process improvement and how to organize a system, but the ability to bring the clinical expertise, best practices, outcome measurement and to set clearly achievable, clinically defined improvement benchmarks—I think that's something that the system would benefit from.

Mrs. Liz Sandals: Was identifying one lead agency key to putting this together?

Mr. Bill MacLeod: In our mind, it was. Yes. They weren't prepared to fund it as piecemeal.

Mrs. Liz Sandals: So you had to get somebody who actually was responsible for looking at the bigger picture.

Ms. Angela Jacobs: A lot of our health service providers—at least three of them—stepped up to volunteer for this role. So we went through our criteria and selected CMHA Halton.

Mrs. Liz Sandals: So there was actually almost an RFP for who's going to be lead?

Ms. Angela Jacobs: Yes.

Mrs. Liz Sandals: This is getting clearer to me. You made an interesting comment about 50% of the primary care physicians being outside the LHIN system because they're in a family health team or are individual practitioners whom you don't fund. So you've got no hold on these folks. If, instead, the person with the problem presents to one of these 50% of primary care physicians who are outside your system, can they refer to the CMHA lead and say, "Okay, I want you to put my patient, who didn't go to the emergency room, through this same track."?

Mr. Bill MacLeod: I'm not sure where we're at with this from that perspective. Part of the rationale for funding this was to reduce emergency stress and strain. Ideally—you're right. That would be where we would want to be able to end up. We'll have to see what resources we can bring to bear on that, because right now it's really the commitment—

Mrs. Liz Sandals: The track that you're on is really the LHIN trying to reduce pressure on emergency rooms and also looking at community funding of programs rather than hospital funding. So you're looking at that ALC, emergency-room, wait-time funding to do this, so if somebody is sort of outside the institutional bits, they may still be floating around there outside the institutional bits.

Mr. Bill MacLeod: Unfortunately, yes.

Mrs. Liz Sandals: That's really interesting. So now, let's go back to Kevin's 15-year-old. Now we've got a 15-year-old who presents to the emergency room with

the same mental health and addiction issues. What happens to the 15-year-old who has got the same issues but wrong age?

Ms. Angela Jacobs: We were having those discussions—there is a steering committee that is implementing this program. We are having those discussions. No one's going to say, "This person can't come into this program." It's going to be on a case-by-case basis, but again, depending on the youth, how young they are, whether they're going to fit into these types of programs, where it's all going to be adult—

Mrs. Liz Sandals: So let's assume they don't fit into this particular track of programs. Then what?

Ms. Angela Jacobs: Good question.

Mrs. Liz Sandals: Okay, so we run into this falling-off-the-cliff thing. Okay.

Ms. Angela Jacobs: Yes, absolutely.

Mrs. Liz Sandals: Thank you. That's very helpful. Sorry if I sound like I'm picking away at you. I'm trying to understand what connects where.

The Chair (Mr. Kevin Daniel Flynn): Maria, did you have any questions?

Mrs. Maria Van Bommel: Just a couple of questions, because this has covered a lot of the things I was wondering about. How long has this process been on the ground—actually working on it?

Ms. Angela Jacobs: It hasn't, yet. We've just hired all the new staff. They have gone through, last week—

Mrs. Maria Van Bommel: So this hasn't really been tested yet?

Ms. Angela Jacobs: No. We had an orientation—

Mrs. Maria Van Bommel: Are there other jurisdictions that have something like this that you can use as a model or template for this?

Ms. Angela Jacobs: It was based on a similar model, not quite the community supports that we've provided, but North York hospital with Saint Elizabeth Health Care had done similar—like going into the ED with crisis workers to help facilitate that. We've gone a bit further and expanded a lot more of the community side of it, in terms of case management and withdrawal management. We started with the base of what they had done with the hospital and the ED department.

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Mrs. Maria Van Bommel: So are you basically running a demonstration for other LHINs? You mentioned other LHINs that were doing something similar. Are they doing this or are they doing something that's unique to their LHIN?

Mr. Bill MacLeod: When I mentioned other LHINs, some of them are working on other aspects of the mental health and addictions problem. What we're seeing, as I say, in North Simcoe Muskoka—I know they're looking at how to bring existing agencies together to this single-door, no-wrong-door concept. I think in Waterloo Wellington a similar approach is being made to make sure that the agencies are much more collaborative than they've been in the past.

In a previous environment, they all had their own individual relationship with the Ministry of Health. I think what we've brought is a requirement that they not only have relationship to the LHIN, but that whenever we meet with them, we're meeting with them collectively, that they develop a relationship with each other in that process as well.

To some extent, they're starting to see the advantages of working collectively together. There has always been, I think, in the field a strong sense of ownership of our program and how we developed it. It was often developed on the classic heroic leader who got involved, got a program up and going, fought with the government to get funding—whatever it took. So those organizations had a lot of independence built into them from that perspective, but what they're now seeing is, by working collaboratively and collectively together there's an ability to move forward.

As you know, the LHIN legislation doesn't allow us to interfere with their governance. We're not mandated to say, "Well, we're going to move you all together into one organization." But by bringing them together, I think they work much more collectively and much more synergistically together.

Ms. Angela Jacobs: Excuse me; can I just get back to your comment about the youth? I just wanted to correct something. They won't fall off the health care page. We have a lot of organizations in our LHIN that are not funded by us but they do provide those services to the youth. So the hospitals will connect with those particular organizations. But again, as you know, the capacity probably isn't there and there may be some wait times involved, but there are those types of programs specifically targeted at youth.

Mrs. Maria Van Bommel: And there's no coordination of those?

Ms. Angela Jacobs: There is.

Mr. Bill MacLeod: The Ministry of Children and Youth Services works to—

Mrs. Maria Van Bommel: But not through the LHIN?

Mr. Bill MacLeod: But it's not a LHIN coordination, yes.

Ms. Angela Jacobs: This is where our LHIN boundaries—

Mrs. Maria Van Bommel: Thank you.

The Chair (Mr. Kevin Daniel Flynn): I just had one last question. I was interested in your background, Angela, because you bring some objectivity to it, in a sense. People in health care tend to be really passionate about health care.

There was a lady who presented to us in Kingston. You could tell she had a strong business background. Her point was that you can grow and you can harvest and you can export and ship and import and retail a banana, and it ripens right on my counter, but she couldn't get mental health services for her kid. She wondered why the same business disciplines weren't applied to the provision of mental health services as they were applied to a banana,

when she cared a lot more about her kids than she did about her bananas.

I thought that was a very good question, and I thought somebody with a background like yours would have a view on that.

Ms. Angela Jacobs: I have a view on a lot of ways the government's working. My private sector expectation versus what I see in terms of the public sector—so yes, sometimes I am a bit too vocal when I'm going around the halls of the LHIN.

From a business perspective as well, I do see—what would you call them?—inefficiencies or different ways that we can coordinate services and use the best of the funding we have. I do have that perspective, and even in this initiative that we're rolling out, I hope that I've been able to use that perspective in this particular initiative.

As we go through, we're going to track each individual who goes through this whole program so that we won't lose sight of them as they transition from one silo, if you want, or one provider to another provider, because as you know, in any system, as you do a hand-off between different people, different organizations, that's where you can actually have a lot of the issues.

The Chair (Mr. Kevin Daniel Flynn): Just off the top of your head, province-wide—I mean, including the region of Halton, obviously, and Mississauga—what do you see as the top three obstacles that either the system faces, professionals face, parents face or individuals and families face when someday they wake up and they've got an issue? They've got an addiction issue that has crept up on them or they've realized they've got a depression problem, anxiety—whatever. What are the three biggest obstacles that you think they face?

Ms. Angela Jacobs: I think the first obstacle—and I'm not sure how you would handle this because this is with regard to any physical ailment: You never know about the system until you need it. So when you need the system for your child or you need the system for your heart or you need the system for cancer, navigating the system is probably one of the biggest issues, I think, for anybody.

Maybe putting in a little plug for our LHIN, I find that some of these services—the funding hasn't kept up with the growth in the community in terms of per capita investments in some of these programs, mental health and addiction or community programs. I know that's province-wide, but I can also see other opportunities, and we touched a bit on that in terms of back-office integration.

But I think it's more with the silos. I see the silos between mental health and addictions; I see the silos between mental health and addictions and community programs; and I see those silos between them and the hospitals. I think it's really siloed, not only on the ground level but also on the system level, not on the ministry level.

Mr. Bill MacLeod: And often, the person you would want to turn to would be your primary care physician, Kevin. I think the system is confusing to those folks as well: Intelligent people who graduated all the way

through medical school, and they find it difficult to understand the system. So I think we need to improve that interface between primary care and the rest of the system so that that primary care organization, whether they're a solo practitioner or they operate in a family health team with other kinds of resources, has a way to access the system for these resources as well.

The Chair (Mr. Kevin Daniel Flynn): It seems to me that currently, it's almost a fluke of geography as to what service may be available to you. Are you finding that there really is not equity between the LHINs?

Mr. Bill MacLeod: Yes; I think that goes back to how often these organizations sprang up under that heroic leadership model, where somebody had a great idea and worked hard to get it in place and funded.

To some extent, I think the government tried to deal with that, and they continue to deal with that in terms of the distribution of resources. As Angela has pointed out, in high-growth communities, it's a further struggle simply because the community—as I point out, in our LHIN, it's like every year you take the communities of Bracebridge and Gravenhurst and you move them into the Mississauga Halton LHIN—and not just this year, but next year and the year after and the year after. The resources that are there in Bracebridge and Gravenhurst, whatever those resources are, everything from hospital beds to community resources, need to come when those people move into the community.

We're not necessarily attuned to dealing with high growth. The province clearly has adopted a growth strategy, both from a population point of view and other points of view. I think it is important that areas of growth and areas that are designated as places to grow also have a way to get that infrastructure, whether it's community social service infrastructure or—and to some extent, the municipalities do a great job on the roads, the sewers, the police, the fire and that kind of thing, but it's some of the other infrastructure that suffers a little bit in those places-to-grow designated areas.

The Chair (Mr. Kevin Daniel Flynn): Great. Jeff?

Mr. Jeff Leal: If you had the legislative responsibility in terms of looking at the numerous entities that sometimes get involved in providing mental health services in order to reduce that number to make it more efficient in the delivery, would that be something that you would like to have, that power to expedite things?

1650 Mr. Bill MacLeod: It's one that you'd want to use very carefully because—

Mr. Jeff Leal: Oh, I agree.

Mr. Bill MacLeod: Simply because there's a tremendous resource we get in our health care system, particularly from the volunteer board, volunteer members of society who come and work with these agencies without expecting compensation, remuneration or reward. They do that because there's a sense of belonging or a sense of ownership or whatever, let alone the financial resources they contribute through fundraising and other kinds of things. You'd hate to see that lost simply

because somebody felt, "Oh, we'll put these organizations together and they'll be more efficient somehow."

Mr. Jeff Leal: I don't mean to do it in a ruthless fashion, but after careful consideration.

Mr. Bill MacLeod: And in truth, we have that. If the LHINs see that it would be in the public interest to bring two organizations together, then they can do it in one of two ways. We have facilitated integration authority, so we could go to those two organizations and say, "We think you two really need to be together. We're going to provide a facilitator, we're going to provide a resource and we're going to help you work through coming voluntarily to that conclusion." If, in the end, they said, "For this reason or that reason, we don't agree that it's in the public interest," but the LHINs still saw it as being in the public interest, even more so perhaps after the results of a facilitated exercise, we can petition the minister and the minister has the authority to bring those entities together.

Mr. Jeff Leal: Okay. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Liz?

Mrs. Liz Sandals: I was interested in your comments too on the back-office integration or consolidation, because you've obviously been thinking about that from a business model perspective, which is less dramatic perhaps than the total integration of the agencies. What sort of success have you had with back-office integration or maybe even front office? Because a lot of these little organizations have significant administration; it isn't just back-office functions. It's also that everybody has their own executive director, and while executive directors may be lovely people, there's a limit to how many of those you need in the province. So what sort of success have you had in the integration discussions?

Mr. Bill MacLeod: Quite reasonably good success. Things like common intake and assessment forms, for example—which is again a form of discontinuity because somebody wants to do it this way and somebody else wants to do it that way—are all things that we've been able to work on quite successfully. As I mentioned, the education and development program is now an integrated program across the sector, and the entities are seeing good results from that.

There is a provincial mandate to integrate the back-office systems through something called the community care information management program, CCIM. We're actively involved in that. In fact, our LHIN is one of the pilots right now for the mental health back-office integration on the financial side.

Mrs. Liz Sandals: But when you say "integration" in that context, you're talking about people all using the same systems or the same intake criteria so that you can communicate about measuring things or reporting things; you're not actually talking about—I don't know—a consortium that's going to do payroll for all the little agencies within the LHIN or something like that.

Ms. Angela Jacobs: We are working on two initiatives, actually. One is co-location, which you'll see in the package that Bill handed out. That's one of the task

groups, and we're looking at some of our mental health and addiction agencies sharing a location: sharing reception, some boardrooms, meeting rooms, places. But we're actually now expanding that, opening that up to a lot of community agencies, United Way and so on. We're looking for a location in Oakville and in Milton. We hope that, number one, some of these smaller agencies can move out of some of those locations that are not accessible; bus lines don't go there; they're in a dingy corner somewhere in Oakville or Mississauga where it's not a pleasant place to visit. So that you can get a nicer place to rent—

Mr. Bill MacLeod: But the rent was cheap.

Ms. Angela Jacobs: Yeah, but the rent was cheap; right. So that combining their resources, they'll actually get better access, and then you'll have a whole community in this building so that it's not stigmatized. As well, mental health and addictions is actually a health area—

Mrs. Liz Sandals: There are some other services.

Ms. Angela Jacobs: Yes, exactly. The other thing we're looking at is, some of our hospitals are in an organization called Shared Services West where they do bulk purchasing. So we're looking at how we can offer bulk purchasing to all of our community agencies to get the best price for them on everything they buy—computer software. That may roll out to something like perhaps financial accounting and maybe rolling that a little bit farther along that way, but it's still in the early stages right now.

The Chair (Mr. Kevin Daniel Flynn): Any more questions? Thank you very much for coming today.

Mr. Bill MacLeod: We very much appreciate your time. It's a great pleasure.

Ms. Angela Jacobs: Thank you.

The Chair (Mr. Kevin Daniel Flynn): That was really good information.

The committee adjourned at 1658.

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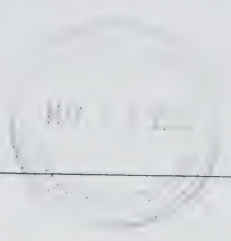
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Mercredi 5 mai 2010

Select Committee on Mental Health and Addictions

**Mental health
and addictions strategy**

Comité spécial de la santé mentale et des dépendances

**Stratégie sur la santé mentale
et les dépendances**

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LEGISLATIVE ASSEMBLY OF ONTARIO

SELECT COMMITTEE ON
MENTAL HEALTH AND ADDICTIONS

Wednesday 5 May 2010

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ SPÉCIAL DE LA SANTÉ
MENTALE ET DES DÉPENDANCES

Mercredi 5 mai 2010

*The committee met at 1550 in committee room 1.*MENTAL HEALTH
AND ADDICTIONS STRATEGY
YOUTHDALE TREATMENT CENTRES

The Chair (Mr. Kevin Daniel Flynn): I call this meeting to order.

Why don't we ask you gentlemen to come forward? We've kept you there, hoping we'd have a few more members.

We had actually hoped to come and see you, because Christine told us about your facility and said it was something we should all see. It was our intent to come and see it, but fate conspired against us with the way the legislative schedule has been working lately. We thought, "We're going to be at the stage where we have to write our report." So we thought that if we couldn't see you, perhaps you'd come and see us instead. I want to thank you for doing that today, and turn the floor over to you and ask you to tell us all about Youthdale.

Mr. Paul Allen: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Please introduce yourselves as well, for Hansard.

Mr. Dan Hagler: My name is Dan Hagler, and I'm the executive director of Youthdale. I will start the presentation.

I'll come forward and invite each of you, any group at any time that you want; you just have to call me, and I'll make the arrangements. I think that this kind of visit not only will give you more because we will be able to give you ample time, but you also will enjoy the fact that you'll see that some of the work that you do behind closed doors has an effect on children. I think you will love it. You have an open invitation, any time you want. Just make a phone call. It's marked on my card.

The Chair (Mr. Kevin Daniel Flynn): Thank you.

Mr. Dan Hagler: I want to thank you for allowing us to speak with you about the work that we do with children and adolescents. I hope it will be of some kind of merit in your deliberations.

We have, at this particular stage, two units in downtown Toronto which are a hospital type. One is an intensive care unit, almost like a schedule 1 hospital for kids who are dangerous to themselves and others. Another unit is an intensive psychiatric unit that is intended to continue with children who feel that they

need to stay a little bit longer until a time when they will settle and be able to integrate and go back with their families or to some of the other facilities that we have.

In addition, we have a few houses in the community. In each house, you have a few kids, sometimes eight, sometimes 10; it depends on the size of the house. At the houses, care is covered by psychiatric and psychological consultations, medical staff as well as child care workers and social workers. We try to help the children in the long run to integrate with their families. Sometimes the children don't have a family, so we'll refer them to the guardian.

The reason that we opted to have houses in the community rather than having an institution is because we'd like, as much as possible, that the lives of the children will be normalized. Not only will the children enjoy other friends on the street, but when the children are capable, they'll go to a regular school in the community. In this kind of arrangement, the transition from our treatment homes to the houses is much easier for the children and the parents.

Many of the children that we have, besides the fact that they have emotional problems, also have learning problems and various other problems. Some of the kids are very complex—maybe my colleague Dr. Scharf will speak about it—and some of them are not doing too well in school. To overcome this kind of thing, we created our own special classes with the collaboration of the board of education. As a matter of fact, many years ago we spearheaded this kind of an idea.

The kids are usually going to our special classes. Within a reasonable time, they are able to integrate within the same school where our classes are because our classes are just in a regular school.

Sometimes the kids find it too difficult to function in their community and they need a school on the premises. For these fortunate, or misfortunate, kids we have a beautiful facility. The facility is about 150 miles north of Toronto on a beautiful lake. The name of the lake is Lake of Many Islands. They live there for some time. They have a school program on the premises and also some kind of a lifestyle with the staff that hopefully will be able to bring them back to the community.

We have an arrangement with all the boards of education wherever we are and those classes are really a great help for the kids to integrate. I know with mental health patients, many of whom you are probably well acquainted with by now, the issue is work; for the

children, it's the issue of school. If the children are able to integrate within a regular school system, even part-time, for the children and the families this is a great success. Needless to say, we also enjoy it a lot because we feel that we are partly responsible for this.

We are about 40 years old. I started as a young fellow with this institution. Sometimes I feel about 100 when I count the overtime, but I wouldn't complain because I notice when meeting some of you that you do the same.

However, the Youthdale development story is going parallel to the vision of the ministry of the government of Ontario for the children. At the beginning, we started with the Ministry of Health. After that, for various reasons that I wouldn't elaborate now, we moved to the Ministry of Community and Social Services. Recently, we moved from community and social services to the Ministry of Children and Youth.

In 1982—yes, I believe it was in 1982; as a matter of fact, I'm sure about it—we were asked by the government at that particular time to develop a hospital for children. In 1981, for those who are not familiar with what happened in the past, there was a concept that children ought not to be treated in a hospital. They looked at the experience that we had with the children and we were asked to develop this kind of concept. The idea at the beginning was to develop 30 beds. As of now, we've developed 20 of them. Problems of budget aren't new to any kind of a government and in 1981 we had similar problems. You are visiting today a similar situation that we had then, with interest rates much lower. I remember when we built it and we wanted to borrow money, interest was about 18% of 19%.

The reason for the hospital is because, in addition to some kind of a support system and their experience in school, it's very important that some of the children who have medical and complex issues and who need an institution go there to deal with them. Even the concept of developing a hospital for 20 kids or 30 kids in itself is unrealistic because what happened is, we were lacking in terms of support for other institutions. With a lot of public relationships, we were able to seduce or encourage the Toronto General Hospital, or what we call now the University Health Network, to become a partner with us. Early in our development we had a relationship with St. Michael's Hospital. As well, we now have a relationship with the school of medicine's department of psychiatry. We are very proud to announce that we are a major partner with the university and with these hospitals and we've become not only a major centre, probably the largest centre of child psychiatry in the province, but we also have become a major place for the training of residents in psychiatry and fellows in psychiatry.

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So this kind of a partnership with the board of education and the health institutions allows us to go on to achieve a lot of things that many other organizations were lacking. As a matter of fact, a few years ago, the American Psychiatric Association gave us a gold award—unfortunately, those of you who wouldn't visit

wouldn't be able to see it, but it's mounted in my office—for having the best psychiatric services in North America in terms of comprehensive services for children. And I believe we still do.

In addition, we have a board that raises money, because there is only limited money that the government can go and support all those noble causes. We opened a chair of pediatric and neurodevelopment psychiatry. We work in collaboration with a few professors in research and other things that hopefully will be able to help our children.

Above all, those things that happened, above and beyond all the nice things and all the compliments, I am most gratified that for about 7,000 young people, we touch their lives annually, some of them with as much as a phone call; others in terms of admission to crisis; others for a longer stay in our residential program, and we're able to make a dent.

This is, in some kind of a nutshell, some description of the agencies, some historical review of what happened, what developed. We have some, however, very interesting features that I'd like to share with you, and maybe you'll be able to share it with other institutions.

First, and one of my most favourite topics that I like to speak about, is emergencies. When we look at emergencies, particularly for children and adolescents, but also emergencies for other people who have problems with mental health, what happens is, we usually rush them to a hospital. We rush them to a hospital, and the people are sitting there for hours and hours because those people who have a mental health issue, they don't bleed and it doesn't look like an emergency. Then, some of them will be discharged and other people will be admitted for the short term.

We didn't like this kind of system, so we came up with an idea: that we have paramedics 24 hours a day, seven days a week, and there is a psychiatrist on call or on duty. What happens is, when you have a phone call, and a child or a family have a problem, the first thing is, we speak with the child or with the family or both on the phone. After that, we go there—we have a mobile service. It means that the people, who are almost like paramedics, go to where the crisis is. They are able to see what the crisis is with their own eyes. Second, they usually find some kind of a resolution; however, sometimes the child ought to be admitted. At that particular time, they'll speak on the phone with the psychiatrist and they'll say, "You're going to be admitted to the hospital." The parents ought to agree. The child ought to agree, but at that particular time there is no waiting time, because once the child is being brought to us, he or she is being admitted immediately. I think it's quite impressive in terms of saving time and not torturing families and children, or any patient, with a long wait in the hospital.

The other thing is, though we are very small, we were able to provide a whole range of medical and some imaging services that the child needs. This means that we can deal with any kind of medical or psychiatric problem the child will have, so we don't have to screen and say,

"This child is too difficult," or "We can't accept this kind of a child." When it comes to MRI and other imaging, because of our relationship with the hospital—St. Michael's, which is just beside us, or sometimes, when we have the time, we use Toronto Western—we are able to go and get the best equipment, and often they consider the child as part of the hospital. If someone is unfortunate to have a child that needs all the medical services and all the attention, they are very lucky to be involved with us.

Now—and Paul Allen will speak a little bit about this—we have an option to admit a child in any part of the organization. If the child has a crisis, we have a secure unit where the child can be admitted. However, if the child has a problem with the school, we don't have to admit him first; what we have to do is make an appointment with the teacher or the people in the department and the child will go to school. If the child needs a school or premises or other situations, we will introduce the child to where the child will be best suited.

However, any one of those children—and some children are very complex—at some time or another during their life, they will be required to be admitted to one unit or another. Let's assume that the child is on some kind of medication and he is going to this beautiful camp that we have, and the medication doesn't help. So we would like to go and review it. You need to do it in a hospital setting. So you ask the child to go and move to a hospital setting, and then he or she will stay for some time. When they are stabilized—sometimes two or three days, sometimes a week, sometimes even longer—then the child can go back.

This kind of a possibility and flexibility allows us what most other organizations aren't able to do, and that's to go in and help the kids, I would say, no matter what the problems are. So the children are moving within the same kind of organization, though they're in a different kind of location based on their needs, and if for a short time they need to be admitted to one part or another, then it's a smooth transition for them, in and out or to another setting.

The other thing that is very important is that we are a community-based service. I agree with the concept—how can you not agree with the concept?—of having children in a normal environment, playing on the street and going to a normal school. We push the envelope up to a maximum in terms of making sure that the children's lives will be as normal as possible. I remember many, many years ago when I had a dialogue with the board of education. They said, "Why don't make a special classroom for those kids?" And I said, "No. It will be easier in the short term, but when you create a special classroom for the children, the children will stay in this classroom and their ability to integrate back to the school will be harder, if any." Therefore, we push all the time, as much as possible, the envelope to create some kind of a normal life for the children.

This is, in some kind of a broad description, some of the things that we do.

I want to tell you something. I have travelled far and beyond this province and beyond the country, and I'm

proud to tell you that the service that we have, at least at Youthdale, can compete with any services in any other place in the world. I've been to Europe many times, and I think that we all should be proud—even with some financial troubles—that we are able to have some places of excellence, where the children who are lucky enough to be admitted get the service that they need.

Again, I plead with you—and I'll make arrangements for you to come and see with your own eyes, because someone told me that one picture is better than five hours of me talking.

However, I'd like to go on. I'd like you to be mindful of some issues that we have a problem with, but I won't elaborate too much. We have a problem with time and with age. Who doesn't? But this is for the children's sake and not for us. When I'm speaking about time, it's that the current arrangement that we have under the legislation is that we are not able to keep the child more than 30 days. You see, this kind of movement from one ministry to another changed a lot of regulations for us. When we were under the Ministry of Health, we were a schedule 1 facility, so if the children needed to go and stay a little bit longer, we could keep them. The law, under the Ministry of Children and Youth Services, is 30 days, come hell or high water. You have to discharge them, sometimes to a place where they wouldn't be able to function. This is an issue that we have in terms of time.

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The other issue is in terms of age. Someone was talented enough, in the legislation, to develop some kind of an age range for the children. For one reason or another, in between the all-conflicting rules and regulations, we aren't able to treat kids, in many circumstances, over the age of 16.

We are integrated within a vast empire of children's mental health centres and we are able to admit the kids at any kind of age, but if we or another agency or another hospital would like to use some of our services when the child is 16 and one day, we aren't able to do this kind of thing.

I'm sure, in your deliberations—by the way, we are speaking with the two ministries at this particular stage, with the Ministry of Health and the Ministry of Children and Youth Services. I see some kind of interest with this. But if in your deliberations you find that our case merits something, I'd like to think that you will at least pay attention and put your mind to this, because this will be of such great help, and Paul will speak about it.

I'd like to rest now, because it's very hot. I'd like to ask Dr. Nathan Scharf, who is the chief psychiatrist with us, to speak a little bit about the kids. It's much more interesting than institutions.

Dr. Nathan Scharf: Thank you, Dan. I would also very much like to thank the committee for having us here today. For me, it's an unusual opportunity to be able to speak directly with the committee and with people who directly may influence or impact the ability to shape health service delivery to kids. It is something that per-

sonally interests me in some of the career choices that I've made along the way, so I'm very pleased to have the opportunity and I want to applaud the committee for the work that they're doing.

Dan said he would speak about the organization and Paul could speak about some of the other things. He said to let me speak about the kids, and I was trying to think about what I should say. Knowing that time is precious and, if anything, it's better to let you ask questions, I decided I would talk about myself as a kid, which is not anything that they're expecting.

As I was thinking about it, I thought that really what my issue is and what my concerns are, in providing service to the young people I work with—the experiences of how I found myself in the position where I am right now sort of reflect, I guess, what my personal agenda and interests are.

I went to medical school in the early 1980s. I was very young; I was very naive. I came to believe—so I was told—that the key to being a doctor was to do internal medicine, because that was the golden flower of understanding what was wrong with people.

I did do internal medicine. I did a couple of years of internal medicine residency in Montreal. By the end of the first year, I was very disillusioned, because what I found—and this was the 1980s; I think things are a little bit better now—was that there was a real emphasis on diagnosis and treatment interventions. What there was not—at least in internal medicine; at least in Montreal at that time—was any integration of services and service provision, and there was really no opportunity to talk to people as people. I became very disheartened by that. I left the program.

I did a little bit of front-line street medicine work, ambulance work, having already decided I was going to go into psychiatry. My interest in psychiatry came via some passing interest in community and social medicine, because I felt that this business with internal medicine had to be broken down. It wasn't human and it wasn't humane. It was, I guess, a sort of rebellious period for me.

What happened, though, was that I found that when approaching medicine just from community and social medicine and public health, you didn't speak with people—at least, you didn't work with people directly—and I love people's stories. Psychiatry, for me, was something that would give a balance between providing active, intensive service and working with people.

The funny thing is that, of course, I wound up in child psychiatry, because this is where I came to work with systems. In adult psychiatry, you deal with adults. Absolutely, in the context of chronic care, it's necessary to work with community and social service agencies. But it was most intensively and most clearly in dealing with kids that service integration and continuity of care were most relevant, because of course the kids were the patients but they weren't usually the clients. The clients were somebody else: It was the parents; it was the schools; sometimes it was forensic and police work.

What drew me to child psychiatry was not a love for children per se, but a real interest in working with and developing systems in service provision and systems in mental health.

I have felt very privileged over the years. When I finished my training, I was very influenced by Paul Steinhauer, who was the head of academic child psychiatry at the time and very interested in families and advocating for families. I was really moved by this. Psychiatry shouldn't be about drugs and pills. It should be about families and providing service to kids in need and at risk in the community.

I felt very fortunate to fall into working at Youthdale, where I have worked ever since—it has been about 20 years plus, now—because what I found in the agency was not only a lot of forward thinking and a lot of interest in systems and system developments but, certainly within the agency, an interest in approaching kids holistically and providing a spectrum of services that go far above and beyond merely addressing psychiatric diagnosis, medication management and treatment.

Dan spoke a little bit about neuropsychiatry services—maybe he mentioned it, maybe he didn't; I don't recall now—sleep clinic and neuropsychological services. We've developed a very rich stew of specialty assessment resources within Youthdale. But that's not really what the agency is about, or at least if it is, that's not why I'm there. I'm there because I'm really more interested in—and over the years have been—providing consultation to the outpatient residential treatment programs, to the community at large. I have, throughout that duration, worked on the crisis unit, which is the intense in-patient unit.

People should be aware: It's a quaternary referral centre. About 40% of our admissions come from other hospitals. Sometimes those are general hospital settings; sometimes those are child psychiatric hospital settings. We don't discharge to other hospitals more often, typically, than about once a year. We've tried to provide a more definitive take and to work more intensively with the community resources to be able to develop discharge pathways and treatment plans so that the kids can be reintegrated into the community and ideally, where possible, go back home to their families. To be able to do that, to take probably about 40 or 50 kids from hospitals—never mind the other 70 or 80 who come from the community or from homes—and to take 98% of them and return them to the community without a need to send them back to another hospital, I think, is really quite remarkable. But we don't do it on our own. We do that because we are partnered and integrated in community service systems. Over the years, we have developed models to effectively engage with and relate to them through partnerships. That's one thing.

Another part of it is, of course, that we do have this comprehensive range of services that Paul will speak about. We have the opportunity, as a crisis unit, to keep kids for 30 days. It's not always long enough, but it's long enough to do a lot more than most of the in-patient psychiatric service hospitals for kids will do.

Where we need to, we can step down on to our transitional unit, which is still secure in terms of the intensity of supervision and support that's available, but it does allow freer access to the community. It does allow kids an opportunity to integrate directly from the unit into school programs in the community. So it provides that continuity of care. The rest of it, of course, falls out through residential programs, special school programs, after-care, family therapy and so forth.

There are limits to the model. I've had the ability in the last few years at Youthdale to be a consultant to the intensive support and supervision program, which is in essence an alternative treatment program or resource program for kids who are young offenders—essentially an alternative measure to provide for kids who have very clear mental health needs. Rather than time in detention, jail or custody, we get them back with their families; get them integrated into the community and provide community-based intensive support. We give them support workers who will see them at home, take them to vocational programs, take them to school and help them get social insurance numbers.

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The idea of providing ongoing care to these young people is critical to their success. At Youthdale, because we provide our focus in terms of in-patient services to kids before their 16th birthday and because those kids will all have legal guardians who are looking out for them, it's relatively easy, given the structures that are in place right now, to provide comprehensive service treatment plans.

Lack of resources is a separate issue. I can't get into it over here. It's easy to come up with plans that would be effective—finding resources is an issue—but the problem is doubly multiplied in kids who are above and into that transitional age: 16, 17, 18 years old. The ISSP program provides community-based support with psychiatric consultation, social work support and psychological services where they need it.

What we can't do at Youthdale is take kids who are over 16 and know where to send them in the community to provide any kind of comprehensive, integrated, holistic kind of treatment. To my knowledge, however good the services may be in Toronto, they're not adequate to the task because those transitional-aged youth, 16, 17, 18—18 is a little bit better already. When they turn 18 or 19, it gets a little bit better.

There are community programs in place—ACT teams; COTA, community occupational therapy—that can provide community-based support for kids and families, young adults in high need. But in that kind of twilight zone between 16 and 18, I am generally at a loss knowing where to send a child who I'm working with, either in our residential programs or because I follow many of the kids after their discharge from the services at Youthdale—where to send them and who they should turn to to provide comprehensive and holistic care until they're 19 or 20 years old, because the services are really very hard to come by.

So, if I want to speak about the kids and speak about advocacy, what I'd say is that I think that there's been a lot of foresight and thought put into the integration of services, at least at Youthdale, for kids up to that age range, but we are shortchanging the needs of kids who are kind of beyond the cusp. That's an area that I would hope this committee would really look to putting additional resources in for service development.

The kids and the adults are better served than those transitional-aged youth and a comprehensive treatment model that can provide continuity of care for that group, I think, is really sorely needed.

I'll be quiet now.

The Chair (Mr. Kevin Daniel Flynn): Paul?

Mr. Paul Allen: Okay. I, too, am mindful of the time, so I will try to be brief. My name is Paul Allen, and I'm the clinical director of Youthdale.

Dan and Nathan have touched upon elements in a graph that has been distributed. It's titled Youthdale Treatment Centres: Sample of Continuity of Care. I thought I could just very briefly take you through a fairly typical intervention for Youthdale.

I would first note that Youthdale's psychiatric crisis service is a resource that's used by mental health and child protective agencies across the province, so those 7,000 calls a year that we receive are probably 50% in the GTA and 50% from well outside. With that sort of ongoing contact with various communities in the province, we begin to develop a sense of what the needs of kids and families in particular communities are, what resources are funded and are easily accessed by children and families and where Youthdale, as a provincial resource, needs to step in and take care of the highest-risk situations where the gap between the need of the child and the parent is most great, compared to, say, what the local hospitals, local children's aid, local children's mental health centres are able to provide.

Youthdale is not generally a well-known program. It's not, say, like the kids' helpline where children themselves or their friends would know to call Youthdale. We tend to be a service that's accessed by families upon the final decision of, say, the family doctor, the children's mental health worker assigned to the family, or often a counsellor or a vice-principal in the school setting who has been concerned about this student for many months, in most cases.

Youthdale is generally not the first place that the child and family turn to for assistance. It may be the third, fourth or fifth stop along what turns out to be a fairly long journey for many of these kids and families as they struggle, usually with multi-generational mental health issues, substance abuse, poverty and other social disadvantages that many of these kids and families bring when they come to Youthdale for help.

For the highest-need kids, the entry point is the psychiatric crisis service. This is staffed by the paramedics that Dan referred to. It's a telephone line that we operate and staff 24/7. It provides a pretty immediate assessment on the telephone to a parent or a professional

who's calling with a concern around a child's suicide risk or a risk that they might present to another family member or a student at school. That team has 24/7 access to a psychiatrist. After they have gathered information and have an idea themselves of how to triage this case, they can always access an opinion from a child psychiatrist to be sure that they have the right level of concern and that the safety plan that they're now going to share with the people looking after that kid will take care of the immediate risk.

Within Toronto, we have a mobile crisis response. Again, this is a service that, as Dan said, operates 24/7. For families, say, who would have difficulty getting their child back to the hospital, maybe where they have been a couple of times—they've had to wait; they were assessed briefly and discharged; the kid and the family are kind of tired of that route—this team will go out to the family home and meet with all members of the family. They're often much more forthcoming in a setting like that in terms of how troubled they are, and their interest in finally getting help may be able to be clarified with the kid and the family, because there's often a big disagreement that has been going on between the kid and the parents about whether they need help at all, what kind of help and what's going to be the bottom line in the household.

After that mobile crisis assessment, we always have a consultation with the psychiatrist. At that point, what we have is usually a pretty good record from four or five professionals who are involved with that kid and the family. We've laid our eyes on the kid and the family ourselves, and we're consulting with the psychiatrist. Out of that, we have a very good clinical sense of the child.

For those who need to be admitted to Youthdale, we have access to the 10-bed secure treatment unit, which is very much like a psychiatric schedule 1 facility. It will take kids involuntarily. Many times, these are kids transported by ambulance from hospitals, or police may end up transporting the child. Large members of the family will gather together to get the kid out of bed, to get them to Youthdale. The kid will often be protesting, sometimes quite loudly and explicitly; other times, they're just very withdrawn and avoidant of getting any treatment. They'll start on that base at Youthdale, at least.

A psychiatrist is part of the interview with the child and the family. We give them some sense overall of what our understanding of their crisis is and how we're going to go about, from the very beginning, not just fixing the kid, who may be identified as the problem, but trying to respond with the family, trying to respond by intervening with their community so that if they're going to go back home, there will be additional supports from mental health providers in their community so that they don't need to go back into a crisis.

At the end of the 30 days—and I'm now sort of looking at step 4—we can transfer the child from our secure unit, where we're limited by the 30-day stay, to

another psychiatric unit, where we can take a little bit more time with the child to make plans and to move the child back on to a longer-term resource.

One of the very frequently used options for the most high-risk kids—these are kids who have depression, who are abusing substances, who have maybe been placed in foster care or residential programs in the Toronto area but have run away from those programs and gone back to high-risk behaviour on the street. With those kids, one of the options that we have at Youthdale that's quite unique is a treatment camp, which is about an hour northeast of Parry Sound. We have three cabins with a total of 24 beds there. For the kids coming out of the hospital settings, where they're agreeable to treatment but we're really concerned about their ability to keep themselves safe if they were placed back in a city-based program, we can start them out in the wilderness, where we sort of have environmental security; where we take away a lot of the temptations; where the school that they'll attend is on-site; where there's a lot of outdoor project education and a working farm program to get them back to basics. Many kids might spend a month in the secure unit, another month in the voluntary psychiatric unit, and then maybe nearly a year in the wilderness program to settle down, get back in school and have the relationships with their family established so that they're not in conflict all the time.

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At that point, we can transfer the child seamlessly to one of our homes in Toronto, where they will be nearer to their families; where we can begin to integrate them into the regular school system; and ultimately where we're going to be able to graduate them back to their family's home, perhaps with after-care support that either our psychiatrists would provide or which we would provide through our family therapy department or perhaps through one of our special school programs that would not need to have the kid in hospital or living outside the home, but will have enough mental health support so that the kid can hold on to the gains they've made and the family can feel secure and able to parent this kid in the next stages.

The Chair (Mr. Kevin Daniel Flynn): Thank you. We're actually at the time when we had planned to go into the report-writing stage. If we do ask questions, I'm sure everyone will have questions. So it's entirely up to the committee.

Interjection.

The Chair (Mr. Kevin Daniel Flynn): Sure. Let's start with Liz, then Christine.

Mrs. Liz Sandals: The referral mechanism, I think I hear you saying, would be from various sorts of other professionals all around the province.

Mr. Paul Allen: That's right.

Mrs. Liz Sandals: Obviously, there must be, if not triage—the answer a lot of the time must be, “We’re already full,” especially if it’s a crisis situation and crisis beds are already full. What would you then say to the person who says, “We’re full”—and I’m not trying to be

argumentative. I'm thinking this is wonderful. But you can't possibly be handling everybody who has the need for this track of service. What are you saying to all the people who call in a panic when you're already full?

Mr. Dan Hagler: Nathan was speaking about integrating with other services in the community. Sometimes we are full. First, because of our relationships with other services, someone will pick up the phone and say, "Listen, I would like you to accommodate this child for three or four days," and they do this comfortably.

Often, when the child is being admitted to us and the child doesn't have parents who are able to co-operate, we try to hook up with another social agency that will provide the services with us.

I can say to you with assurance that we deal with any kind of crisis. Under the circumstances, we are not always able to provide the ideal situation, but we carry the child so there will not be any kind of disaster while the child is waiting for service. This is why Nathan was speaking a lot in terms of integrating our services with the total community.

Mrs. Liz Sandals: Are there other services in the province which are similar to this in structure? You mentioned that you're getting calls from all over the province, which actually doesn't surprise me. Are there other similar services elsewhere in the province?

Mr. Dan Hagler: Not quite as comprehensive as we are. I was part of the committee in 1981. The ambition of the legislators at that time was to provide four or five centres like this. They established Youthdale as the first experiment. After that—I don't have to tell you what happened—in 1982—

Mrs. Liz Sandals: So you're still a pilot?

Mr. Dan Hagler: Yes, we are still a pilot. As a matter of fact, every day I figure it's another experiment.

Mrs. Liz Sandals: The other thing that's confusing me slightly is because at the beginning of the program you're very much like a hospital, but we'll leave that aside.

You said that you're funded by MCYS, and I'm wondering how you get funded by MCYS. What does MCYS think it is funding?

Mr. Dan Hagler: For the social worker and the child care worker, we are funded by the Ministry of Children and Youth Services. For the psychiatric and some of the medical, we are being covered by OHIP or the Ministry of Health. So it's two ministries—

Mrs. Liz Sandals: So some of it you would get by billing OHIP. For the people who are actually medical practitioners, you would bill OHIP.

Mr. Dan Hagler: Yes.

Mrs. Liz Sandals: But you're not getting a hospital bed per diem, because you're not really a hospital.

Mr. Dan Hagler: We get grants, however, for some of the non-medical services that the medical staff are doing, from the Ministry of Health.

Mrs. Liz Sandals: Okay. This sounds like a complicated dog's breakfast of funding, so I won't go any further.

It's a fascinating structure, though, you have in being able to move children through. You said up to 16 years?

Mr. Dan Hagler: Correct.

Mr. Paul Allen: As far as the hospital units are concerned, yes, up to 16. The longer-term programs are admitting kids up to the age of 18.

Mrs. Liz Sandals: Oh, okay. And you might have somebody start off with you when they're 15 in the hospital program, but they could still continue in the program even past age 16, and by then they're in one of the more residential parts of the program.

Mr. Paul Allen: That's correct.

Mrs. Liz Sandals: Thank you very much. Fascinating.

Mr. Paul Allen: You're welcome.

The Chair (Mr. Kevin Daniel Flynn): Sylvia?

Ms. Sylvia Jones: Just a brief question, and I apologize because I did come in after you'd begun. You mentioned that 40% of your patients are coming from other hospitals.

Dr. Nathan Scharf: Yes, I think so.

Ms. Sylvia Jones: Are you doing any diversion from the justice side, young offenders before they actually get charged, any of that kind of—

Dr. Nathan Scharf: The only program that is named specifically as forensic within the agency is the ISSP. That's the intensive support and supervision program. Youthdale was named one of a number of programs within the province that were initiated to provide multi-disciplinary support—MST, we say for short; it's a model from the United States—or wraparound services to provide comprehensive support for youth who had already been convicted of offences within criminal justice. One can say that anything that will provide for greater family cohesion, success and so on and so forth will be useful as primary care prevention or tertiary care prevention.

But, no, we don't have any sort of pre-conviction services. There are limited, within the province and within Toronto, programs that are asked to do forensic assessments for court purposes for young offenders. The old Family Court clinic in Toronto would do young offender assessments as part of predisposition hearings, but we're not doing that.

Mr. Paul Allen: I would certainly say, in my experience, that police are often involved with these kids, whether it's addressing their offences or just giving families a hand trying to control their kids and protect members of the family. They're very reluctant to charge these kids with offences. They assist the family. Many times, the police are involved in recommending a place like Youthdale. They assist families very regularly in getting the kids to Youthdale in a humane way, I would say. You see a lot of effort in the community on the part of police and probation to provide mental health interventions for these kids as opposed to criminalizing their behaviours.

Ms. Sylvia Jones: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Christine?

Mrs. Christine Elliott: Thank you very much for your presentation. Even though I've had the pleasure of visiting Youthdale, I learned a lot again. I certainly would encourage members of the committee to visit, if they're able to do so.

Just a couple of questions; one is: Is there any other agency that offers the level of intensive service that Youthdale offers, or are you the service of last resort for the entire province?

Mr. Dan Hagler: No; as far as I know, there isn't. Part of the reason, I suspect, is that the American Psychiatric Association gave us their gold award for the best integrated psychiatric service, because I don't know any services—and I travel in the United States often—that have this kind of a thing.

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The province, at that particular time in 1981, was very ambitious and allowed us to develop an absolutely superb service. When they found that they aren't able to go and to develop other places, they declared us a provincial facility. So, this is why we serve the total province.

Mrs. Christine Elliott: Another quick question that I had is: You indicated that you can only have children stay in a secure facility for 30 days. What would be the optimum time if you could choose it? Do you think 30 days may not be enough, or would you rather just have more of a discretionary option as to how long?

Dr. Nathan Scharf: It's a problem to not have that discretion. Having said that, it certainly is not optimal to have kids admitted for 30 days. Our average duration of admission probably runs about three and a half weeks, and by virtue of having four weeks and a couple of days—I say frequently to the people whom I'm supervising or teaching that it's always a failure when a child is admitted for 30 days, because then they recognize that they're being discharged because of legal requirements rather than because of progress or gains made. So you work very, very hard to try to create resourcing within the community to get the child out well before the last moment. A child being there 30 days, given the context, is something of a treatment failure, or it could be construed as such.

Absolutely, there are some kids who will require more than 30 days for stabilization and for treatment. Typically, those will be the kids who have a clear axis I major psychiatric diagnosis. Primarily, work with adolescents is psychosocial intervention: a lot of conduct disorders, a lot of substances, a lot of depression, a lot of trauma. Now we're seeing more and more neuro-psychiatric kids, but even leaving those aside, because those will often present younger, when you're dealing with transitional youth, the kids who are older—15, 16 and especially 17 and 18—you are seeing the first onset, for most individuals, of major psychiatric illness: schizophrenia, bipolar disorders. Unfortunately, the major initial gist of intervention is going to be psychiatric and medication management. The psychosocial supports and networks and working with family are extremely im-

portant—just as important in terms of long-term care. But that's down the road, and more community-based.

To treat a new-onset psychotic individual will usually take more than 30 days. When I mentioned that 49 out of 50 kids—or actually, it's probably closer to 79 out of 80 kids—we'll be able to discharge back to the communities: The once a year when we're phoning around to other hospitals to transfer is almost invariably in a child who is psychotic; you need more time for that.

Mrs. Christine Elliott: If I could, just one more question: Dealing with a reluctant patient, what do you do in situations where you, say, have a 15-year-old that really doesn't want to be there? I think at my previous visit we've touched briefly on that, about an equivalent to the Consent and Capacity Board. Could you just speak about how you deal with that and what happens in those instances?

Dr. Nathan Scharf: Certainly the first, primary goal of the psychiatrist and the treatment team when these kids come to the unit is trying to find something—and it can be almost arbitrary; it doesn't necessarily have to be what the parents or guardian is most concerned about—that you can hook the child into to form a meaningful therapeutic alliance with him, because you can't provide any meaningful work if you're fighting with a child for 30 days. One of the skills that people develop—if they're going to be satisfied doing this work; if you can't do it and you're not happy with it, you won't be in the field very long—is finding something—and I would say that you have a window that generally runs about 48 to 72 hours—that can be meaningful for this child, essentially forced into a psychiatric setting against their will, that they feel they can meaningfully get out of being there. Sometimes it's just, "You need to work out something with your parents so they don't keep on feeling that you need to come to places like this." But even that is something to start. If you can establish that, you can get contact with the child and parents around treatment goals. That, we are able to do probably 90% of the time.

The other 10% of the time, we have kids who will—because they all meet with advocates within 24 hours of coming to the unit, and the advocates will explain to them their rights, as we ourselves do at the time of admission, that if they absolutely feel that they don't need to be here and that admission is unjustified, they can request a legal review. There is a process of legal review board hearings which are similar but not the same as hearings under the Mental Health Act. Those hearings will take place within five days of a request. So if a child absolutely is adamant that they don't want to be at the setting, it may take them somewhere between five and seven days to be able to activate the mechanisms to try to force the issue of an unplanned discharge.

Mr. Dan Hagler: Sometimes kids leave, in spite of our best accommodations. There is some kind of legal process that they don't like to be labelled. It's so complicated that sometimes children, against their parents and against their guardians, are being sent back to the street because this is what the child wants. But most

of the kids, on the other hand, just to go and to suggest: First, we have a unit that the child can come to, a unit that is not secure. It's only when there is imminent danger for the child and for others that we'll go with admitting them against his or her will. Many of the kids ask to move to another intensive psychiatric unit in the same building, and they do it only if they volunteer to have it done.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Maria?

Mr. Paul Allen: Maybe just a final comment?

The Chair (Mr. Kevin Daniel Flynn): Go ahead.

Mr. Paul Allen: In terms of the length of stay and, "Is 30 days sufficient in most instances?", besides the clinical work of stabilizing the dangerous behaviour of the child and bringing specialists together at the same time and in the same place to really figure out what's underneath all of these behaviours and emotions that are turning everything upside down, part of the calculation we have to make at Youthdale that's putting our average length of stay out to 30 days—and in many cases, we would prefer to have the flexibility to go longer—is not the clinical issue with the kid, per se; it's trying to match a resource in that kid's community, to advocate to the local children's mental health and the medical professionals in those communities to have a buy-in to the discharge plan that we're building now that we have the child stable and we've understood a number of the underlying reasons for their distressing problems. They'll still need ongoing help, and if it's not going to be through a program at Youthdale, many communities need time to get themselves organized, to align, to move these kids and families, if not to the top of the list, at least in a reasonable way, try to accelerate their involvement with this kid. They have to recognize that this kid and family is one of their highest needs or they wouldn't be at Youthdale. Rather than having a relapse, they need to do something differently from, say, 30 days before.

That length of stay is not just the clinical work with the kid and family; we also take the time, which many other programs won't—certainly in hospitals—to align local mental health providers to a plan to keep the kid well so that they can preserve the gains that they've made while in the hospital setting.

The Chair (Mr. Kevin Daniel Flynn): Maria?

Mrs. Maria Van Bommel: Just a couple of questions: First, someone mentioned, in response to Sylvia's question, about forensic. Are any of the beds at Youthdale funded through the justice ministry at all if you're dealing in forensic?

Mr. Dan Hagler: The answer is no, and even if they were funded under the legislation, we are not able to go and deal with those children because we have a limit of 16 years old.

The Chair (Mr. Kevin Daniel Flynn): I think you need to speak closer to the mike so that Hansard can hear you.

Mr. Dan Hagler: The legislation binds us to go to work up to the age of 16. Those people that you're speaking about: Usually most of them are older.

Mrs. Maria Van Bommel: Your system uses residential treatment and right now I'm sure you may, if you've been following the news at all, know that in Sarnia-Lambton there is a girl's community home which is operated by the St. Clair children's mental health agency. The home has, at best, seen about a two-thirds occupancy rate, so the agencies board has decided to close it because of the underutilization of it. They're telling the families and the community that foster homes is the trend now in this.

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I'd like to know what you think about the foster home approach to children's mental health in terms of providing what we talk about as "normal" and having kids who are going to community schools and participating in the community be seen to be going to a normal home, or the whole issue of runaways. You mentioned runaways and what happens there. Is this the trend? Are we seeing a trend in this direction?

Mr. Dan Hagler: No. This is the most loaded question I was ever asked in any place. What happens over the years is we try to develop services, because of a lack of money, that require less and less money. Sometimes they don't make any kind of sense. It's like a child who's coming to us because we look as if we know all the answers, but the child and the issues are much more complex.

I don't know too much about the service that you are speaking about, but the reason that they are not full may be more to—yes, and I don't think it's just simply that the service is not needed. There is a pressure at this particular stage on children's aid societies and other institutions to cut their budgets to find a cheaper, less expensive way to deal with children, but having been 40 years in the field, I think it will backfire. I've seen it several times. I know that services are being closed not because they are not good and there is a new fashion to do it; it's because there are not enough funds to do it.

Dr. Nathan Scharf: If I could just comment. I think anybody who works with kids would have strong feelings about this kind of issue. To me, it never has been, nor should it be, an either/or. There are some kids—and I'll say most kids, probably, who, for whatever reasons, come into the care of the children's aid society or other agencies who can and should be placed in parent-model foster homes. The kinds of kids whom we are treating and who need these residential programs are kids who generally have been in one or more foster homes first and failed in those settings because the foster homes, while people will legitimately see them as being a more normal kind of family model than treatment settings, cannot provide the degree of structure, supervision and support that the foster homes can.

Nobody would be advocating against foster homes. Sadly, foster homes fail in providing adequate resourcing for many of the kids we wind up dealing with.

Mrs. Maria Van Bommel: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thanks, Maria. I have a few really short questions. You said 30

days are granted to a child as a stay? That's the most that they will fund under MCYS?

Dr. Nathan Scharf: It's not funding. Legally, the Child and Family Services Act, under which we admit children to our unit, will only allow a single 30-day admission. It's a legislative piece, not a policy or funding piece.

The Chair (Mr. Kevin Daniel Flynn): So it's a single 30-day admission in their lifetime?

Dr. Nathan Scharf: No, no, no. You can readmit.

The Chair (Mr. Kevin Daniel Flynn): After what period of time?

Dr. Nathan Scharf: Twenty-four hours, 12 hours, 10 minutes.

The Chair (Mr. Kevin Daniel Flynn): Okay.

Dr. Nathan Scharf: I think, historically, over the last number of years, we've had about a 12% readmission rate. I think it was higher earlier on. Now we do have more resources. For kids whom we really don't feel are ready to go and who do need longer time in terms of the psychosocial rehabilitation piece—we're not talking about diagnosis or medicines. But for that piece, this is where the transitional unit, which opened up 12 years ago, has been extremely helpful. Nevertheless, some of the kids will get readmitted. I think in my career, the largest number of readmissions we've had to the service was five readmissions for a total of six admissions for one particular child. That's in the 20 years I've been there.

The threshold to readmit obviously gets higher and higher. We have less new to say or offer the second, third or fourth time around. We'll sometimes admit a child at 10 years old and can see them four or five years later for completely different reasons.

The Chair (Mr. Kevin Daniel Flynn): As we travelled around the province, one of the groups that talked to us a lot was the fetal alcohol syndrome people, saying there's a lot of misdiagnosis going on, in their opinion, and that things we're diagnosing as ADHD and other conditions are actually fetal alcohol syndrome. Would you agree with that statement? Are you seeing evidence of that?

Dr. Nathan Scharf: I would see evidence of that. I'd probably have to say I'm guilty of that myself. Certainly, in the last two, three, or four years, I am seeing a lot more cases, maybe because I was naive to it earlier on. We were all aware of it, but part of the issue is diagnostic. We'll see a lot of kids who have neurodevelopmental markers of intrauterine alcohol and drug exposure, but to make a diagnosis of fetal alcohol syndrome, you need certain specific physiological markers. It's an issue of morphology in addition to having a very clear history of intrauterine exposure. Very often, we have kids who look like it and feel like it, but we don't have the history, or we have a clear history, but you can't make the diagnosis by virtue of having lack of physical features. So you're left with, I'll say, a lesser category of alcohol-related neurodevelopmental disorder, which is really more speculative. But absolutely, we're seeing a lot more of it now—or I am, at least—than four or five years ago.

The Chair (Mr. Kevin Daniel Flynn): Okay, that's one. Are you seeing an increased incidence? You've been around in the business, you've said now, since 1981. Is it increased incidence or increased diagnosis?

Mr. Dan Hagler: It's very hard to say. They're in combination, but I'll try to say it straight.

First, the flavour of the last few years is to go and be involved with fetal alcohol syndrome. We are serving in a role with some work with Sick Kids hospital. On one hand, you have an awareness. So you know if the child is not this, not this and not this, and there is nothing else, maybe it's this kind of a thing. Then you look for some kind of information. Surely, with many of our children, we'll find that the parents were involved with drugs. The second thing is, over the years, the drug culture has become a much more prevailing thing.

The other aspect is, with the advance of technology in the medical field, we create children who have problems today that they never had before. The idea just a few years ago was that to have a child, you had to come to term or close to term. Today, after 20 or 22 weeks, you can deliver a child. You keep it in incubation, and this child will look cured until the time the child is two, three, four or five. There will be no cure, because there is something in the brain that wasn't developed.

So there's a variety of ingredients in this kind of a thing: first, the knowledge that we have; second, the technology, on the other hand, that the doctors develop.

Dr. Nathan Scharf: I'd like another 30 seconds, just because I think it's worth saying. There's an old expression, "If all you have is a hammer, everything starts to look like a nail." A lot of what happens in psychiatry is a function of political and advocacy waves and movements. Now, I think that there is a great need for additional servicing for kids with FAS, so I'll exclude that.

But I think that a lot of what has happened in psychiatry is that certain conditions have had explosive increases in numbers of diagnoses recently, because new treatments have become available that people are willing to give to treat conditions. If doctors are reluctant to make diagnoses for conditions that they can't treat, and as more treatment options become available, sometimes you find that the criteria around various disorders shift suddenly or dramatically. That has been most clearly the case in the last 10 or 15 years around bipolar disorders in children, but there are certainly other conditions where one might wonder about how diagnosis is following treatment resources rather than the other way around.

Mr. Paul Allen: One thing I would say on that issue, whether it's FASD or another factor, is the more Youthdale spends time working with the kids who are falling through the cracks of the systems that we have built—and Ontario, compared to many jurisdictions, is a very wealthy and well-resourced service system. Whether it's provided in health care settings or in community settings, it's very rich.

The kids who come to Youthdale are the ones those systems aren't figuring out and helping. More and more,

what we're discovering is it's not a matter of providing counselling, encouragement or psychosocial help for those kids. Even psychopharmacology doesn't give you the sort of benefit with these kids that you would want. We find they're on multiple medications, sometimes prescribed by different doctors over a long period of time. But what we're figuring out more and more—again, whether it's FASD, a genetic factor or an acquired injury—is there's something about the function and the structure of the brains of these kids that makes it very difficult for them to learn from experience; it makes it very difficult for them to learn from treatment, which is partly an educational experience for these kids. They don't understand a lot of spoken or written instruction. Their ability to remember things is difficult. Their ability to hold on to things that they might understand in one situation—when they're under stress, that understanding goes out the window.

What I would say is that the people who are raising FASD as an issue should get credit for raising the understanding that there are a lot of difficulties that these kids have in understanding how we're going about trying to help them. Their lack of response to those efforts doesn't mean that they don't care, that they don't appreciate or that they're not trying their best; it's that we have to bring together a different team around those kids, in a way, to understand all the challenges that they're facing—some of them are cognitive and neurological—and the strengths that these kids have.

Let their families understand—this is not a matter of bad parenting or neglect or parent-child conflict. There

are factors here that are beyond the social and familial cycles. There are millions of dollars invested in services for these kids. You have to take a different account of that.

It's hard to replicate an institution like Youthdale, but part of what you see here is the evolution over time, where we've taken good community-based mental health services built in an institutional setting, when kids are really dangerous and out of control and either don't understand or won't accept that they need help, and where you can have the critical mass of specialists working together in one place to give answers in a quick way and then give people back in their communities enough time to build the discharge plan, to have the resources, and the backup of Youthdale in carrying out the continued work with those kids.

The Chair (Mr. Kevin Daniel Flynn): Wonderful. Thank you. Are there any more questions? If not, thank you very much for the time you've given us today. Thank you very much for forgiving us for cancelling our visit to your facility. I think each of us, in our own way, if we're able to, will try to make it down, if you'll allow us to do that.

Mr. Paul Allen: It would be our pleasure.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Thank you very much for coming.

We're going to recess and go into closed session for the report writing, and we're going to get France on the phone as well, so she can participate in that portion.

The committee continued in closed session at 1702.

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